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First ingredient in the formula for healthy personality development is a mother's natural expression of love for her child. When this is impaired or distorted by environmental or inner strains the child may face emotional starvation—one of the greatest hazards that can confront a budding personality. Three articles in this issue describe efforts to ward off or combat this danger.

◀ *the authors*

In addition to her part-time work as therapist at New York's Northside Center for Child Development, Clara Rabinowitz carries on a private practice in psychotherapy and serves as a consultant to the staff of the Utopia Day Care Center. Three schools of social work—Pennsylvania, New York, and Smith College—contributed to her training, as did the William Alanson White Institute of Psychiatry and the Washington Institute for Mental Hygiene.

Olivia Edwards has also added considerable postgraduate study, much of it at the New York Psychoanalytic Institute, to the basic professional training in social work she received at the New York School of Social Work, Columbia University. At the Northside Center she serves as therapist for adolescents and for parents of children being treated in the clinic. She also conducts parent-education groups at the center and in nursery schools.

Mother of a mentally retarded child, Letha Patterson, of St. Paul, Minn., is one of the founders of the parents' movement which has resulted in the National Association for Retarded Children and its numerous local and State affiliates. In her continuous efforts to further public understanding of mental retardation she has served as public speaker and lecturer before both professional and lay groups and has written and edited numerous pamphlets.

Ruth Cumings was mental-health consultant in the Westchester County (N. Y.) Health Department when she and six other nurses drew on their experience at the Mamaroneck Health Center to prepare the article on parent-discussion groups on page 18. She is now studying for her doctorate at Teachers College, Columbia University, New York.

Brigadier Jane E. Wrieden, officer in the Salvation Army for over 25 years, received her professional training in social work at the University of Buffalo, School of Social Work. With experience in children's institutions and foster-family programs and in maternity homes and hospitals, she has conducted many institutes on services to unmarried mothers in this country and in Canada.

Casework service to children has occupied Lorena Scherer ever since her first job at the St. Louis Training School for Feeble Minded Children back in the early Thirties. Before going to the Missouri Division of Welfare in 1938, first as a regional child welfare supervisor, she was with the Board of Children's Guardians in St. Louis. She attended the New York School of Social Work and the School of Social Work, Washington University, St. Louis.

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SOCIALLY DEPRIVED CHILDREN

I. THERAPEUTIC WORK

CLARA RABINOWITZ, M. S.

Psychotherapist, Northside Center for Child Development, New York

> One of the outstanding trends revealed at the 1955 meeting of the American Orthopsychiatric Association was an awakened interest in extending therapeutic services to those groups of children too long rejected by many child-guidance and social-casework agencies as not amenable to treatment—especially children from socially and economically deprived areas. The two papers presented in these opening pages, which were part of a symposium on the subject, describe the way one voluntary agency is attempting to adjust its therapeutic techniques to meet the impact of social malignancy on children, parents, and therapist. They are evidence, along with Lorena Scherer's article on protective casework on page 18, of social work's growing determination to reach out and persist rather than to give up in the face of "resistance."

SEVERAL TYPES of children are accepted with reluctance by many psychiatric clinics: the delinquent, the retarded, the schizophrenic, and the child who lives under base social and economic conditions. This article is concerned with the children requiring treatment and living under submarginal conditions. It has these objectives: first, to encourage wider exploration of the relatedness between the variables in personality and in the social and economic backgrounds of children; second, to consider whether children living under submarginal social conditions can be helped psychiatrically; third, to examine some problems which arise in therapeutic work with such children.

In the preparation of this paper, the clinic records of a group of children known to the Northside Center for Child Development in New York City have been reviewed. These children are not typical of the clinic population, which is of varied background. Their records were chosen for review because they have all lived under grave social and economic conditions such as bad housing in slum areas, overcrowding, inadequate clothing, insufficient medical care, no personal possessions or spending money; strained, quarrelsome home atmospheres. Some are latchkey children. Most of them attend poor schools. Reviewed together their case records reveal a number of similar therapeutic problems.

The following three summaries are greatly telescoped:

Martin

Martin is the only son among four children. The irregularity of his father's work as a longshoreman forced the family to recurrent applications for relief. The mother responded to the frequent changes in economic status from subsistence level to something less with feelings of humiliation.

The father was asthmatic. Periodically he fled his troubles and responsibilities through weekend drinking bouts with men friends. The mother was depressed and enraged because of the poverty and the limitations it created for the children.

Martin was referred to the clinic because he could not learn to read or write even in a class for slow learners, and because he would fall asleep in school after long periods of reverie. The clinic physician found the boy to be more than 12 pounds underweight. Psychological testing indicated that his inability to concentrate interfered with full use of his capacities as a dull-normal child. His characteristic way of coping with anxiety or conflict was avoidance. The psychiatric history suggested that Martin's asthmatic condition since infancy, in a home of very few material resources, might have made of him a "cherished nuisance." It also indicated that the attention he had had as a sick child, and the mother's later restriction of his social life because of the hazards in the slum neighborhood, might have contributed to his very dependent, distant, and uncommunicative behavior. The clinic's tentative diagnosis, before therapy, was "neurotic character disorder in a chronically ill boy." Remedial reading work was recommended along with therapy.

Despite Martin's inability to volunteer anything for the first 6 months of therapy, the clinic continued to work with him from the time he was 12 until he was 14½ years old. Because neither parent participated actively in these efforts (the mother refused contact after several interviews in the clinic and in her home), the therapist was left with a technical problem of how to understand and how to give Martin a basis for understanding his periods of serious depression. She had to choose between drawing mainly upon her knowledge and experience about nonverbal people, and utilizing the very meager data about his family life in the record as a basis for her procedure. Feeling that she knew too little about the interaction in the home, and fearing to risk reactive upset in the boy, which might impel the suspicious mother to remove him from the clinic precipitously, she relied chiefly on her general knowledge about very aloof, uncommunicative people. The other course would have been to tackle, in language understandable to Martin, the dynamics of his response to a distant but overprotective mother and an escapist father who left him without support in coping with his own problems.

Ann

The case of Ann is still in process after 2 years. Referred by a public agency for youth, Ann, an obese but otherwise good-looking Negro girl of 14, was nervous, stuttered, and resorted to screaming when provoked. She was in the eighth grade and falling behind. Tests pointed to intellectual capacities significantly above her achievements.

The psychiatric consultant, coordinating all the data, noted that "it is difficult to separate the overwhelming reality problems from the psychological difficulties in Ann's problem in living. . . . Ann's minimizing her problems may be an example of the mechanisms of denial, but on the other hand, denial to some degree may be a necessary maneuver under such stress. [All of the symptoms] point in the direction of neurotic mechanisms which may be hindering Ann from coping fully with the severe deprivation she must deal with." The diagnosis and differential diagnosis were: (1) neurotic reaction to severe deprivation; (2) situational reaction to severe deprivation.

The eldest of eight children, Ann lived with her parents and siblings and another family of seven—altogether 16 other people—in four very substandard rooms. She had no possessions and no place to study or to store schoolbooks or her very insufficient clothes. Her parents cared a great deal about her but were too restrictive about association with boys and about allowing her to meet her peers on the street, as was the custom on the block. In a limited clinic contact, the father, an unskilled worker whose income was supplemented by public assistance, appeared discouraged for himself and the family. The mother, visited in the home when she stopped coming to the clinic, appeared lethargic, almost too accepting of her situation. At the same time, she resented the lack of necessities for her home and children.

Because of Ann's very real material needs, much of the therapist's time during the interviews was devoted to doing concrete things for her; and when the family life became even more complicated (the father deserting and the mother becoming hospitalized for tuberculosis), the therapist had to assume even greater responsibilities. As Ann and the therapist became more deeply acquainted, therapeutic goals evolved. The first was to help the girl to become aware of her terrible resentment at her degrading life situation. The purpose of this was not so much to "release anger" as to establish a reality basis for her hurt, as distinguished from the attacks on her self-esteem she felt from teachers, friends, and others when no hurt was intended by them. Another goal was to clarify her distorted views of the relations between men and women, about marriage and about responsibilities among grownups, and to show her how these views had developed from her experience in the two families with whom she had grown up and how they contributed to her irrational anger. She had to become aware, too, of her covert, destructive maneuvers with her peers. The therapist had to risk Ann's open anger against her parents even though she knew how little Ann had beyond her relationship with them.

In her efforts the therapist was very often overwhelmed with discouragement for herself and for the girl, feeling that she could not do enough to matter, and that Ann already had too many real responsibilities to be able to bear any anxiety that accompanied the therapy.

Matthew

A school nurse sent Matthew, aged 11, and his mother to the clinic. Matt was seventh of eight children. He could not learn to read and was having to repeat grades. His mother was resentful of her husband, who was much older than she, because he remained retired from the Navy although his pension was too small to provide basic family necessities and because he did not participate in the family life. Her apathy made her appear intellectually limited. She was very restrictive and punitive with the children in her effort to keep them out of trouble.

Matt was seen in the psychological study as a child of average intelligence, functioning at the level of a 6-year-old and relating to adults with dependence, helplessness, and great aloofness. The diagnosis was "severe neurotic disorder with possible schizophrenia"; the prognosis was guarded.

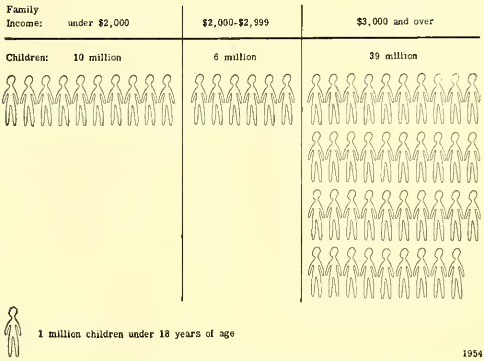
The therapist, finding no indication of change after many interviews, requested psychological retesting to check for possible intellectual retardation. In the next few months Matt began to participate in games more appropriate for his age. However, the original diagnostic impression remained after 10 months of therapy. After a summer break, Matt returned to the clinic more alive and acting more his age. He continued to function on an increasingly higher level. He also began to show improvement in reading and in school work generally. After 48 interviews in a total of 21 months, therapy was discontinued as both therapist and Matt were satisfied that he could carry on and continue to grow. Matthew's mother also responded well to her experience with the social worker.

Problems of Deprivation

In all these cases the therapist was faced with problems arising from the child's deprivation.

First, there was the problem of the interpersonal connection between child patient and therapist. Work with these troubled children often evokes in the therapist such strong feelings of sympathy as to arouse an overprotective attitude. At the same time, the child's frustration may overwhelm the therapist with hopelessness about being able to assist him.

CHILDREN AND FAMILY INCOME



More than a sixth of the Nation's children are in families with total incomes of less than $2,000 a year, nearly a third in families having $3,000 a year or less. When economic strain is severe, family relationships are often adversely affected.

Another aspect of the interaction is more creative. It is the positive aura which springs from love for him and pain for his suffering and so cannot fail to communicate itself to the child. Not only is this imperative to the therapy but it offers the child an experience which he has seldom been able to get from the significant adults in his life because of their preoccupation with their own burdens and with a sense of failure.

The therapist's feelings may interfere in the therapeutic process with these children as they may in any other psychological work. Therefore she must constantly criticize her own role in order to correct her perception of the data as it emerges. For example, when Ann continued to distort the motives and actions of others and to view her improved, although still undesirable, situation with the same old bitterness, the therapist could recover from her immediate response to Ann's depression and see that the girl was persisting in dealing with a new environment as if it were the old.

Similarly, when Martin continued to deal with the therapist in the same aloof way as when they were comparative strangers, the therapist, at first feeling that this child could do no better because too little had been done for him, was able to become aware that in the therapy, a truly new situation, Martin was acting as if it were an old one and in this way was clinging to the familiar, destructive though it was. Then the therapist could point out that even if Martin's total reality had not changed, he was in this quite different relationship not returning anything for value received. This approach offered the child the chance of learning something different about human interchange.

So it is that the task of the therapist with deprived children is to steer a course between enough identification and too much. Nevertheless, an involvement in the child's life of great deprivation is mandatory. One cannot remain detached and help these youngsters therapeutically.

Another serious barrier which arises in working with such children is that the therapist must often work in the dark. This is true when parents are unable or unwilling to participate in the treatment. It is especially defeating for children too young to tell about their experiences, or incapable of verbalizing.

One may ask why a clinic would undertake to work with children whose responsible relatives do not collaborate. In our clinic such cases usually have begun with participation on the part of some responsible adult, who, as in the case of Martin, has withdrawn from contact after the child has become involved. Perhaps it would seem wiser to present such parents with the alternative of giving up clinic service for the child. However, our view has been that if the children themselves are benefiting from the therapy, it would be double hurt to drop them when they cannot be treated in the usual manner.

Nevertheless, the disadvantages created by the nonparticipation of a parent are not to be denied. We not only miss the opportunity for the kind of clarification with the child which comes from knowing the environmental events precipitating his changes in feeling and behavior, but the therapy loses the force derived from the parents' interaction with the clinic. The therapist is especially handicapped in being unable to evaluate, with any degree of accuracy, the mental status of the parents with whom the child is interacting. When the clinic has the aid of an adult informant the therapist is on more solid ground in building a view of the reality of the child's life and his way of coping with it.

For example, in dealing with the possible sources of Martin's depression, the therapist had to choose between leaning on theory or on the too meager facts known about his situational and interpersonal reality. The therapist chose to lean toward theoretical understanding about why and how children become depressed. This led to too much abstractness and too little introduction about events in Martin's life and about his misinterpretations concerning them. Such an error is too easy to make when data is not available from direct contact with significant adults in the child's life. The necessity for a strong and mobile casework program in a clinic is apparent.

The Parents

Several factors must be considered in respect to the behavior of socially deprived parents toward their children. Often they do not show love in conventional terms. However, their behavior with their children does not seem to reflect rejection or lack of love or of concern. Many of these parents have all but lost any motivation to change even the material aspects of their lives. Some have lapsed into passive acceptance of uncertain income and coauthority over the purse strings with public-assistance officials. More have grown bitter and to hate their lot and the people they believe associated with it. They have little energy left for any open show of tenderness to their children.

These parents express deep devotion for their children, but they do this in terms of how they must struggle to provide the barest essentials for the child. They express their love through their anger and unhappiness in not being able providers. Feeling that they must protect their children from the dangers inherent in slum life, they are often extremely restrictive. Thus they prohibit contact with the opposite sex, street play, or attendance at any but the closest play centers. Thus they are often harsh disciplinarians in an effort to ward off delinquency and to strive for decency in their children. While such parental attitudes often create in the children feelings of not being loved, we therapists must also see in these attitudes the struggle in the parents for something good.

Since they feel that they are doing all that *they* are capable of doing for their children and are too burdened by care to reach out for change, these parents require much stimulation from the outside. They come to the clinic with a kind of depressive, sometimes apathetic, immobility, leaving the clinic to carry for a long while the burden of the struggle for change.

The ordinary interviewing techniques alone are insufficient to motivate these parents to change. The clinic's degree of expertness in working directly with the child and its willingness to be available to and to assume responsibility for at least the early months of contact with the parents, are positive determinants for such motivation.

A further point of difficulty in work with children of submarginal backgrounds is loss of the cushioning effects of community resources available to children of families with more economic leeway. Here enter the problems of too little clothing, no money for carfare to go places or to call the clinic, limitations in general knowledge, insufficient encouragement from others. Without material aids such as camp, outings, clubs, parties, petty cash, clothes, special classes, the therapeutic changes in the child often have little chance of becoming consolidated.

Since the therapist more often than not comes from a different economic class than these children or their parents, she may be dependent upon some material things that they have never known or depended on. Thus, she must always make an effort to see whether her conventional view interferes with a correct understanding of a child's response to his reality. This is not the same as "adjusting" to the child's deprivation.

Modified Practices

At our clinic we have learned to modify theory and practice in order to work with children who are deprived in so many ways.

First, and foremost, stands the clinic's readiness and willingness to use its services for children who will tax its resources to a much greater degree than other children.

Next, we have learned that a parent's reluctance to use psychiatric help when he reaches the clinic on referral may be associated with great inertia and depression arising from feelings of rejection by society. When we meet the parent with an understanding about this he may be more able to use deep psychiatric help. This raises a question about the psychiatric conception of "the self-determination of the client"—whether or not a clinic's efforts to break down a parent's reluctance to treatment for himself or his child is a violation of his freedom of choice. Where sick children and apathetic parents are concerned, the clinic would seem to have a responsibility to engage in a struggle with parents, with the goal of helping them to pull away from their apathy. This is not to imply that psychiatric services must force their help upon apathetic applicants. It merely means that apathy can exist on both sides.

Another result of our experience is in respect to psychiatric diagnosis. In assessing the strengths which therapy may count on in the child's personality, we have to make allowance for the dulling influence which the environment and the parent's restrictions may produce. Children like Matthew and Martin appear gravely ill, possibly to be undergoing an active schizophrenic process. We have learned, however, that reality factors may produce a similar effect. In Matthew's case, the malevolent process was reversed through treatment. Although Martin did not change so markedly, there was sufficient intrusion of a different kind of reality experience, via the therapy, to make this aloof, seemingly inanimate child, respond more openly to others, on a less special and less dependent basis. It also made it possible for him to look forward to new and hopeful experiences, such as attending a trade high school, with hope and pleasure.

A still different aspect of our dealing realistically with the child's realities is to accept his complaints and explanations, such as inability to compete socially because of insufficient clothes or irritability due to lack of privacy as facts and not as resistance. Our acceptance permits the child to know that we respect his view and understand his situation. At the same time, we attend to sifting out the real from the unreal, thereby coming to distinguish the child's distorted generalizations from his experience.

We have also learned to continue working with the child if he moves into any degree of relationship with the therapist even when the usual aids to therapy are absent, and when there is no responsible adult having regular clinic contacts. We continue despite the gaps in such aids, knowing that our work will be slower and more difficult for patient and therapist.

Sustaining Forces

In such instances, the immediately sustaining forces for the therapist are:

1. The growing relationship between therapist and and the child. In this relationship the child is increasingly aware of the therapist as a friend who is trying to discover the truth with him and the therapist is aware of the child as a person who is earnestly seeking the truth for himself.

2. The reliance on theory and experience. This enables the therapist to look for a pattern in the child's behavior with others (in these instances, mainly his behavior with the therapist) which is most characteristic of the misinterpretations. It also enables the therapist to present the child with a different

view of himself than the confused self-image he has. This process of picking up the child's characteristic difficulties, of helping him to understand their source (when the child is old enough for this), and of helping him to see how he defeats himself and what a poor view he has of himself is backed up by the therapist's conception of the child as he would appear if stripped of his handicapping distortions. The contrast between the therapist's "good" view and the child's poor self-image becomes the therapeutic focus in the struggle for change.

We have also learned that it is sometimes necessary to intervene in the realities of the children's lives. As Dr. Augusta Bonnard of London has said in an informal communication to a colleague, ". . . therapy for a hungry or grossly deprived child is a bad joke—and the child will feel it is being made a fool of. Hungry children must be fed, even in a child-guidance clinic . . ."

Recognition of the environmental reality with its potential for influencing the personality must be accompanied by recognition of the psychological reality which the child experiences in his interpersonal relations with significant adults. Because in Martin's case specific information about the family's interpersonal relations was not available in sufficient detail, it was necessary to theorize about it.

With Ann, it was necessary and possible to be explicit about the force of life history (her parents' poverty and their efforts to create a different life by their marriage, even if at too early age) in considering what she regarded as her parents' peculiar behavior and how this had greatly determined her own unique distortions about other people. Making such direct connections relieves the child of guilt about his articulated or unspoken criticism of a parent. At the same time, it takes away the onus of wilfulness in a parent's hurting a child. It helped Ann to feel more affection for her mother and pride for her striving to hold the family together. While it could not help Ann to love a father who broke down under the weight of so much responsibility, it did help her to express directly her disappointment, hurt, and disgust. She began to differentiate her view of her father from her observations about boys she was now meeting. Ultimately, she felt she was meeting and having fun with male compeers without feeling ill at ease or exploited.

Goals and Chances

Working with mentally ill children from socially and economically submarginal environments poses the problem of goals as does any other psychological activity. If infants all were born into equally adequate external conditions and had equally sound health they would have infinite possibility for creative use of themselves. When optimal conditions for growth do not obtain, some damage is likely to occur. We, as their therapists, can only try to release the greatest degree of capacity possible within the time and skill at our command and within the children's limits.

A general goal is to enable the child patient to want to master more aptly whatever exists in his environment that may help him become more independent—school, friends, or recreational opportunities—and to find constructive ways of getting, or at least showing a need of, the material things he requires.

A combination of a seriously substandard environment plus grave family disorganization is conducive to serious disorganization in the personality. The child who comes from a family where there is a semblance of interpersonal unity and organization and an ordinary amount of love expressed in emotional terms has a better chance of being helped by therapy than the child from a home without these advantages. So has the child in whose behalf some responsible adult will collaborate with the clinic.

It follows that a child not yet old enough to verbalize his problems or to have some experience independent of the home has less chance of getting enough help when the realities of his life are unwholesome and when he attends the clinic without an adult.

Nevertheless, given flexibility in therapeutic method and the willingness of clinics to serve them, many children who suffer the combined conditions of mental illness and grave social deprivation can be treated psychiatrically. The greatest aids to the clinic in these efforts are the qualities of human resilience and desire to live which the children and their parents bring with them, however shrouded these may be in the beginning.

SOCIALLY DEPRIVED CHILDREN

II. HELPING THEIR PARENTS

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PARENTS who have had to use their energies fighting for existence amidst malignant social conditions are often too worn down and involved in this struggle to enter into any intensive and intricate examination of themselves or their relationships to their children.

Yet our experience at the Northside Center for Child Development has shown that success in treatment of children from deprived social backgrounds depends to a great extent on how much their parents can also be involved in treatment. It has also shown that for such children and their parents approaches which deviate from the usual clinical approach are required.

The caseworker's usual methods of focusing on neurotic patterns of behavior in parents in order to effect some changes in their attitude and behavior is an important and proper part of his functioning in a child-guidance clinic. However, there are some people for which these methods, by themselves, do not work, such as those from deprived families.

As psychiatric casework developed from the material-giving, sympathy-giving approach to the use of psychodynamics, an older form of treatment once used successfully has been more and more neglected. I refer to an emphasis on the environment, the first area in which the caseworker assumed his professional role. Dr. Irene M. Josselyn has pointed out: "With the recognition of the effect of the impact of the environment upon the individual, it became apparent that if the environment were modified, the individual's pattern of behavior might also be modified. Children were removed from undesirable homes and schools, adults were helped to find congenial jobs and adequate recreation, and disturbed individuals were protected from excessive pressure from reality as they struggled with their internal conflicts. The results in many cases were, and continue to be, excellent."[1] An adapted use of this older form of working is pertinent for deprived families.

Environmental Help

We found an application of this approach useful in our attempts to help Mrs. R., a Negro mother, who despite physical and financial hardships, managed to move her family (consisting of her husband and five children) from a sharecropper's farm in a southern State to a crowded tenement neighborhood in New York City. She had been referred to our clinic for help for the youngest son, Jim, who was a problem in school in that he would not protect himself against the aggressiveness of other children, ran out of his classroom whenever scolded by the teacher, and was fearful at home.

At this time both parents and children in Mrs. R.'s family were being treated for syphilitic illnesses, one daughter had a malignant lung condition, and one daughter suffered from rheumatic heart disease. The father's earnings had to be supplemented by public assistance. As time passed the two older boys became narcotic addicts; one was arrested and imprisoned for breaking into a store; the other made an immature marriage; Mrs. R. was operated on for a tumor on her larynx and subsequently lost full use of her voice so she could not speak above a whisper.

This family of seven lived in two small rooms on the top floor of a badly kept boardinghouse. On becoming acquainted with Mrs. R. the caseworker was made immediately aware of her deep hostilities which had grown up out of many bad experiences in the South, but which she easily transferred to all people in authority with whom she came in contact.

It is obvious that Mrs. R. needed all the support, all the identification, all the attention a caseworker could give her. This seemed the only sensible way in which to maintain her interest in coming to the clinic. This does not mean the worker sat down and cried with Mrs. R. about her troubles; rather she became actively involved in helping her to deal with housing authorities, welfare investigators, narcotics experts, police officials, health agencies, and the like. While this was going on it would have been devastating to Mrs. R. to attempt to help her face an additional burden—knowledge that she had contributed to her children's inability to adjust to the pressures and temptations of a new environment and had contributed to Jim's anxieties and poor relationships with other children and teachers.

The caseworker had to set aside her own fears that Mrs. R. would become too dependent. As she accepted the necessity of giving Mrs. R. moral support and of actively helping her in her dealings with people in authority, a relationship developed between them. Mrs. R. could begin to understand and digest the caseworker's little remarks about the effect of her anxieties, hostilities and fears on her child and to consider how her domination of her family played a part in the deterioration of the older boys.

Because of this relationship, in which the caseworker used an active supportive role as a conscious technique, Mrs. R. was able to try out the caseworker's direct suggestions for dealing with the realities of her environmental problems. Finally, as she became free of many of her hostile feelings toward herself and toward others, Mrs. R. accepted her right to disassociate herself to some extent from the problems of her grown children, to absolve herself of responsibility for their behavior and to begin to have some life for herself.

Because Mrs. R. came to the clinic in dire need for help with problems based on a breakdown in economic, environmental, and health factors, these reality needs were given priority in the treatment relationship. She was thus motivated to continue her appointments.

Mrs. R. had been a leader in her southern community, had good native intellectual ability and had participated fully in the social and political life around her. She had personality assets which had carried her through past hardships and which were revived as she was helped with the new kind of hardships arising out of her new environment.

But there are other clients whose economic deprivation is compounded by other problems which make them even more difficult to reach. These are people who seemingly have less native endowment, who have led isolated lives and who have been unrelated to the wider community activities around them. Living constricted, socially unaware existences they usually do not come to the clinic of their own volition but only after persuasion or in response to demands of referring agencies, who represent to them authorities whom they must obey.

The Isolated

Mrs. A. is a mother who is apparently limited intellectually. She had been sent to a hospital mental-hygiene clinic with her daughter, a nervous, jumpy child, after the little girl cut off some of her hair. This clinic had given the daughter diagnostic tests and referred her to Northside Center for therapy. Mrs. A's chief concern was about her daughter's hair and throughout the clinic's contact with her she held to the belief that the child, who was being seen by the therapist once a week, was in some mysterious way getting treatment for her hair.

The caseworker who saw Mrs. A. once a week encouraged her to express her ideas about things as simple as the color scheme she would choose for a new outfit of clothing. This interest and acceptance gave Mrs. A. a feeling of self-worth. When the caseworker told her about plays for parents and children being presented by a local "Y," she began attending these with her little girl. Then, at the caseworker's suggestion, she enrolled her daughter in the Girl Scouts.

Using the relationship developed with Mrs. A. as the result of these tangibles, the caseworker discussed the daughter's need for some independence—for encouragement to express herself as Mrs. A. had gained encouragement for self-expression from the caseworker. The caseworker also helped Mrs. A. to reach a point where she could tell her daughter about her illegitimacy and why her father could not live with them, although he came to visit and contributed toward her support. She thus was helped to dispel the child's distorted ideas about sex and the father's role in the family and to modify much of her own feeling of guilt. Work in this case was limited, but Mrs. A. and her daughter left the clinic with a better sense of their own value and a better emotional connection between them.

Matt's Mother

The worker who saw Mrs. S., mother of Matt, described by Miss Rabinowitz, contributed to the therapist's success in working with him by her ability to involve Mrs. S. in the treatment process. Burdened by financial problems, a disinterested husband, and a large family, Mrs. S. had an extremely limited social life. On the defensive and reluctant to admit to any difficulty in handling her children, she practiced strict control over them. However, she saw Matt's need for remedial reading and on this basis sent him to the clinic. She kept appointments at first out of her great respect for authority but without the least idea of changing her relationship to her child.

The caseworker maintained this mother's interest by arranging for Matt to attend the clinic free of charge and by getting him a bus pass for this purpose—thus recognizing her limited financial resources—and by accepting her need to accompany Matt thru "the dangerous neighborhood" to the clinic. In the second interview when Mrs. S. apologized about discussing the family's troubles, the caseworker said, "This is a very real worry with prices going up," thus setting the stage for attention to Mrs. S.'s practical problems and encouraging her to come regularly for appointments. Despite the limitations of the discussions due to Mrs. S.'s lack of spontaneity, her constricted personality, and her isolated life experiences, the worker persisted in seeing her. She realized that Mrs. S. needed a person with authority who would listen to her with respect and who could accept her childlike, dependent way of responding.

Work with Mrs. S. was halting, elusive, tenuous, but worthwhile. Once when the caseworker suggested that Mrs. S. might resent being told what to do about Matt, Mrs. S. replied, "No—you are helpful and I try to do as you say; I know it's to make things easier for me, and the children gain from it."

In order to help Mrs. S. feel more comfortable in social contacts, the clinic invited her to join a group of five mothers who met once a month with one of the social workers. This group had been started as a device to offer some of the socially compressed parents an opportunity for more human contact, for interchanging ideas and experiences. The group, apropriately named The Social Group by one of the mothers, blossomed into a verbal, active "club." The mothers had relatively animated discussions about themselves and their families, and once had a party.

On two occasions the social worker took the group to museums and once to a downtown show—an entirely new experience for them. It is difficult to describe their feelings of discovery and happiness. The theatergoing and contact with the group was an important factor in opening up a new side of the world for Mrs. S.; it enabled her to feel closer to the caseworker, who had brought these things into her life. Mrs. S. was therefore able to verbalize some of her deeper feelings.

Gradually Mrs. S. softened toward her children. At the end of 23 sessions, the worker observed of her: "Her world was very small and her contact at Northside Center has widened it for her and helped her change somewhat in relation to the children." Direct suggestions had been made to her concerning her handling of her children, and she had had enough confidence in the caseworker to try to follow through on these suggestions. Her experience in the social group had made such an impression on her that after her contact at the clinic ceased she joined a community recreation center.

The effect of the total clinic contact was good for Matt. His most striking behavior characteristic, which was to act like a defective child—although he rated average intellectual ability on tests—showed marked symptomatic improvement after 48 sessions. He became a less constricted, happier boy and in his relationship with his mother developed some ability to choose.

A Combined Role

In the last two cases, the worker's approach was limited to staying with the mothers at the level and pace they set—similar to the way in which the therapist accepted Martin's slow and irregular pace. as described by Miss Rabinowitz. These parents could not be hurried, nor could they digest more than simple suggestions. Yet, they seemed to emerge happier and more aware of their children as individuals.

We cannot overlook the fact that to hold oneself to the psychological limits set by a Mrs. R. or a Mrs. S. calls for infinite patience on the part of the caseworker as she sits through slow-moving and repetitive interviews. The kind of "reaching out" described in Mrs. R.'s case involves visits to the home, the school, the hospital, and other agencies. Often these parents are too hostile—because of having had many disappointing experiences with schools, hospitals, police—to understand how these agencies want to help. The caseworker has to step in as the parent's representative until she has been able to help them to approach these agencies with more positive attitudes. In situation after situation she teaches the parent through example to develop such attitudes.

The supportive role of the caseworker is most important when working with adolescents. Many adolescents develop hostile, fighting-back, oppositional defenses against the deprivations in their lives. They are not in the mood for treatment based on self-examination and see only the unfairness of their life situations with all the frustrations involved.

Miss Rabinowitz has pointed to the necessity in some cases of intervening in the realities. The caseworker is often in a more fortunate position for this than the therapist, since she works in the clinic on a full-time basis rather than by the hour as the therapist does. Moreover, by tradition, and often by inclination, the caseworker is more apt to accept the role of part therapist, part big sister, part helpful and sympathetic authority for the adolescent. This involves, in addition to office interviews, going out on trips with clients and on visits to home and school. In some cases, the adolescent begins to imitate the caseworker's social behavior, accepts her as a real friend and borrows her ego strengths.

It is true that these approaches add to the pressures of a caseworker's job and require a decision to be made as to how much time can realistically be put into this type of service.

It seems to me that enough important and lasting gains came from the physical as well as mental efforts put forth by the caseworker in the cases described here to warrant sincere consideration of the efficiacy of this kind of work in helping people. We have to reexamine our own attitude and feelings about doing this kind of job. We have to be aware of our own readiness to reject what may seem to be the more lowly task of offering tangible help which is the only kind of help to which some people are ready to respond when they come to the clinic.

In a psychiatric clinic, where the major function is to practice dynamic, insight-developing, psychiatric casework, it is possible to work with cases which at first seem hopeless because of the grave all-around deprivations, if we are willing to consider the social aspects of our job along with the psychiatric aspects. Dr. Sol Ginsburg recognized the psychiatric worker's conflict in this respect when he wrote:

"We have been hampered by the erroneous prestige which has come to be associated with dynamic therapy as opposed to what seems to be looked upon as the more humble desire and skill of 'merely' helping people. . . . At a case presentation made jointly by a psychoanalyst and two social workers, the accusation was made that they were too identified with the patient and hence overprotective and even 'loving.' The patient was a badly neglected, utterly deprived child, and it seemed to me that a perfectly adequate theoretical case could have been constructed for the techniques employed. But what interested me more was the need of several of those who participated in the discussion to find some technical justification for such feelings, some sanction for them in dynamic terms, as if just loving the child was somehow suspect." [2]

In summary

Although our chief mode of operating our child-guidance clinic is through the use of insight and interpretative therapy, we have found that some very deprived people require a supportive environmental approach to encourage them to a more constructive view of themselves. Sometimes this becomes the goal of help and sometimes it is combined with efforts to achieve direct insight. Sometimes it is preliminary to a more intensive psychiatric approach.

This supportive approach involves a conscious use by the worker of self and aids in helping the client to cope with his environmental pressures. It differs from the practice of giving help in the Lady Bountiful days of social work, inasmuch as it takes into consideration the psychological needs and drives of the client. The caseworker helps the client to develop as much insight as possible into his neurotic patterns, but does so through lending active help in many troublesome and frustrating experiences. Always the worker aims to help the individual become a more integrated person who will be assuming increasing responsibility for his behavior towards others and himself.

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[1] Josselyn, Irene M.: Psychosocial development of children. New York: Family Service Association, 1948.

[2] Ginsburg, Sol: The impact of the social worker's cultural structure on social therapy. Journal of Social Casework 32: 319–325, October 1951.

A mother of a retarded child suggests . . .

SOME POINTERS FOR PROFESSIONALS

LETHA L. PATTERSON

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ONE of the most heart-warming aspects of being the mother of a retarded child these days is in being a part of a profound partnership which is developing between lay and professional people.

Of all life's problems, those presented by a handicapped child (and particularly a mentally handicapped child) require the utmost in teamwork within professions, among professions, and between professional and lay people, especially parents.

All over the country we parents are attempting to assume responsibilities appropriate to the partnership through helping to define our separate roles and in heightening our communications in order to save other families from unnecessary trauma.

Dr. Martha M. Eliot, Chief of the Children's Bureau recently said:

"When officials of public agencies ask what kinds of services should be provided for retarded children, my advice is 'ask the parents' . . . [they] are often best qualified to say *what* help they need, though professional persons will have to provide the *hows*." [1]

Thus, we laymen and professionals are indispensable to one another in our efforts to make up for past neglect of this serious medical, emotional, social, and educational problem.

Perhaps I can bring together for the readers of this journal for professionals some of the written and spoken insights which have come my way from both professional workers and parents. These, I feel, are relevant for those of you who find it your task to help families face this heartbreaking problem—whether you are physicians, psychologists, social workers, nurses, teachers, or administrators. On the basis of these and my own experience I urge:

1. *Tell us the nature of our problem as soon as possible.*

When I said this to a class of students of child psychiatry at the University of Minnesota Medical School, I was asked by an alert student, "But Mrs. Patterson, what can the physician do when he is not sure himself and doesn't want to worry the parents?"

"Just be honest with us," was my reply.

It takes great sensitivity and intuition to take a mother's couched remarks and detect that they spell "worry." Often we parents are concerned just as early as our practitioner, but we are reluctant to put our fears and worries into words. However, we give plenty of hints that we want our professional counselor to help us get them into words, to lead us on the proper course—whether that means waiting a while or consulting with specialists immediately. It is a wise counselor who knows when he does not have the answers and is willing to admit it.

One of my psychiatrist friends put it this way: "When I am faced with a worried mother or father *I have got a problem.* Either there is something wrong with the child, or something wrong with the parents, or both. And if I can't identify the trouble, then I am obligated to get this family to someone who can."

2. *Always see both parents.*

Fathers are parents, too, and all professional workers need to be reminded of this. Both parents should be present whenever possible, and at least on first consultations regarding a child's handicap.

It is very difficult for a mother to go home and restate, interpret, and answer questions about a prob-

Learning the truth is an agonizing experience for a parent of a badly handicapped child, and suspicion of mental retardation may be fought off desperately. When a father does not receive a professional explanation directly, he may refuse to accept the reality the child's mother can no longer avoid.

lem she does not clearly understand herself. Often the problem, with its fears, has brought about a lack of communication between mother and father. This is particularly true in a young marriage or when the retarded child is the first child. Establishing adequate communication is difficult in any marriage. Finding the words to support one another in *this* problem has been impossible for some of us. We have needed an objective person through whom to talk.

Unfortunately, all husbands (and wives) are not like the one who, when he learned that their little daughter would not progress like other children, said to his wife: "Honey, we don't know what lies ahead of us—but whatever it is, we can handle it because we are strong people."

Many of us can find this strength, however, if you will help us.

Another reason for seeing both parents is that both need to be pulled along together in their understanding and acceptance. I have seen too many mothers who realized the need for institutional care and were ready to "place" a child while the fathers trailed behind ignoring reality, not to recognize the great need for a common understanding. Sometimes it is the mother who will not admit that something is wrong and insists that her child stay in regular school classes when a special course of study is indicated, while the father suffers along in silence, afraid to precipitate the issue. If you but knew the isolation that can exist behind our four walls!

3. *Watch your language.*

Parents need to understand the implications of their problem, but too often we are given professional gobbledegook, or at the other extreme, plain talk of an obnoxious variety. Words like "idiot," "moron," and "feebleminded" used to be excellent and descriptive clinical terms but they no longer apply to our retarded children. Unimaginative writers and purveyors of so-called humor have polluted the meanings with connotations of social or moral deficiency in the mentally normal.

On the other hand, there was the doctor at a residential institution who wrote to two parents stating that their son was ill with "cervical lymphatic adenitis." The worried family did considerable research to find that the child simply had swollen glands of the neck.

The child psychiatrist, into whose capable hands my husband and I finally could put our problem, was very sensitive in his use of words. He avoided "moron," "feebleminded" and even "mental retardation" by encouraging us to evaluate our child's developmental status. And when he confirmed our findings, we felt quite pleased with ourselves. He always referred to our boy as "your son," "your lad," or "Stephen" with a voice filled with great compassion so that we started thinking more about Steve's problem and less about our own hurt egos.

4. *Help us to see that this is OUR problem.*

One way, of course, is by example—by not taking the problem over for us.

Too many well-meaning professional people in the past have thought they knew what was good for us and have recommended, even insisted on, institutionalization. We know, now, that denial of the existence of the child is not the solution for either child or parent, that abandonment is not the answer, and that it is psychiatrically unhealthy to rob parents of their responsibility for planning. Only as we parents are helped to work through our problems can we find any peace of mind. If we have not planned for our child ourselves, if someone else has made the decisions, we have not really made up our own minds and so must keep going over the ground again and again. We may never be at peace with the solution which was reached for us.

Administrators of institutions tell us that the best help for families in adjusting to their child's placement is the fact that the parents themselves have decided—with adequate professional guidance, of course—that placement is best for the child in relation to the total family welfare.

There is another reason for showing us that this is our problem. You have no idea how much unprofessional, unsolicited, and untried advice we get from well-meaning people—our neighbors, relatives, friends and even strangers standing on street corners. When, with your guidance and example, we realize that *this is our problem*, we can shut our ears to the static and rely on our own judgment. But we need your professional support in helping us to feel competent in making these decisions, your confidence that we will ultimately make the proper decision for care in our particular case, your assurance that there is no failure if we change our plan when circumstances change—life situations and retarded children present different problems at different times. You can help us explore the possibilities for meeting our problem; support us in adjusting to our decision; act as a continuing sounding board against which we can bounce our own thinking; and give us a good, sturdy shoulder on which to lean when we get dizzy going through the maze of decisions.

5. *Help us to understand our problem.*

Parents differ in the quantity and quality of information they can absorb during different phases of this problem. What they want and need depends greatly on the individual, but many of us have had to search for the knowledge we needed in order to understand our child.

Six years ago, when I began my search, a severe scarcity existed in printed material on the subject of mental retardation. Today, there are many fine and helpful publications in this field. One of the best that I have seen for new parents is Jacob's "New Hope for the Retarded Child,"[2] which is inexpensive enough to be used as a handout. Many other books, bibliographies, journals, and pamphlets provide excellent sources for parents.

Regardless of what we parents are able to read and absorb, we will always have questions to ask. We will continue to need support from someone, whether our child is at home or away—particularly in those days which follow the confirmation that mental retardation *is* our problem.

One medical counselor asks parents to come back several weeks after he has given them the bad news, knowing that they will have questions which could not come to the surface during the emotional strain of hearing the verdict. Moreover, he sees to it that the parents get to a social worker and he also urges them to join an association for retarded children.

Frequently he turns their names over to the local association's "parents counsel committee" requesting that some mature couple—a mother *and* a father—call on them. He has found that parents who have successfully faced their problems can offer a special kind of help to new families which transcends his professional services. Further, he has seen the therapeutic effects of parents working together in organizations to improve the lot of the retarded and their families. Incidentally, he was initially one of the "pros" who were afraid of this "lay" movement.

6. *Know your resources.*

In referring to services, Dr. Eliot has called the retarded child "nobody's baby." Certainly there is evidence in most States that services are disjointed and uncoordinated. Rarely is there any one place which can put parents in touch with the resources that *are* available.

In Minnesota, where the county social worker is the local resource for parents, a booklet, "You Are Not Alone," telling parents where and how to seek help, has been distributed to members of the State medical association, county welfare boards, clergymen of all faiths, family and welfare services, clinics, public-health nurses, associations for retarded children, and newspaper editors in the hopes that the booklet (or the information) will be passed along to parents. It was produced by the statewide Conference Committee on Mental Deficiency, a professional-lay body.

California has started meeting this problem with information centers for the parents of retarded children, set up in Los Angeles and San Francisco by the State department of mental hygiene. The psychiatric social workers assigned to this task have a variety of functions—counseling individual parents, putting them in touch with resources, providing information to public and private agencies, and serving as consultants in community planning.

Other States are developing a network of clinics with built-in social services for the sustaining help which is so necessary.

Anyone who has carried a handicapped child from one waiting room to the next in an effort to gather resources into one piece, will appreciate the significance of these several efforts to avail parents of the services that do exist.

7. *Never put us on the defensive.*

All parents make mistakes in raising children. Those of us who have a retarded child are bound to make errors, but we should not be made to feel guilty about them.

One day I said to my medical counselor: "You know, of course, that I was angry at you for a good long time for 'confirming my diagnosis,' but never once have you put me on the defensive about it or any of the mistakes that we have made in relation to Steve."

"Why should I?" he countered. "How do I know I could have done any better than you, had I been in your circumstances?"

He went on to give this definition of "good parents":

"Parents are good parents, when to the best of their ability, understanding, and circumstances, they meet as adequately as possible the needs of their children."

8. *Remember that parents of retarded children are just people.*

This has been *my* most amazing discovery. We are just people with a serious problem, a great sorrow—a living sorrow. We have the same strengths and weaknesses as others in the general population. We have the same problems, the same handicaps. But when the burden of mental retardation is heaped upon us, often these problems and defects are magnified and we, in turn, create problems for those of you who must deal with us. But *as a group*, I do not think we should be considered abnormal, particularly in view of the poor cultural attitude towards our problem, the lack of interest and services, and the fact that some parents have made great personal and family sacrifices to carry this "cause" to the public conscience.

You cannot generalize about parents of retarded children any more than you can generalize about retarded children. Gifted, average, or limited, any of us can find our problems complicated by our own emotional makeup. Professional people working with us must learn to appraise these variables in our intelligence and emotional stability.

Apropos of this are the technical articles which some of us read. Why do we *always* face such words as "anxieties, hostilities, frustrations, guilt-feelings," and other emotionally charged words to describe our reactions? Such pseudoscientific certainties merely serve to make parents feel even more inadequate, it seems to me.

You should take seriously the comment of a New Jersey parent: ". . . Is not what appears to be 'guilt feelings' to professionals, merely concern with the child's welfare, mingled with grief over his handicap?"[3]

"All parents experience some feelings of guilt about illness in their children . . .," Dr. Julius B. Richmond, pediatrician, of Syracuse University has said. If outward manifestations of these feelings persist in us after you have assured us that "no act of omission or commission" on our part has been responsible for the condition of our child, perhaps our feelings might be more aptly described as "regret." We are bound to feel regret if we have rejected this child, if we have struck out at him and created problems for him. With this regret we very likely feel anger at not having had the proper guidance at the times we needed it.

Might not some of our hostility be nothing more than righteous indignation over the neglect of our problem? Actually, if some of the pioneers in the parent group movement had not become "mad" in the early days, our problem would still be largely ignored. Who can say, on the basis of present knowledge, when anxieties are neurotic overreactions, if parents must ask: "What will happen to this child after we are gone?" "How can we pay for expensive care outside our home?" "Where can we hire a sitter so that we can take a vacation?"

Whatever labels we use for these feelings, they have added up to a great determination—you might call it "compulsion"—for some of us to see to it that new parents coming along can walk a smoother path. And there is considerable evidence that many of these new parents are avoiding some of the emotional scars which some of us bear.

Dan Boyd, a New Jersey parent, has described three stages in the growth of a parent of a mentally retarded child: (1) Why did this happen to me? (Self pity.) (2) What can I do for my own child and family? (3) What can we do for others?[4]

These stages can be intermingled. The fact that a parent is working in an organization "to help all retarded children" does not necessarily mean that he has grown with his own problem. Some can be stage-3 leaders, without having graduated from stage 1. Such self-pitying parents are the hardest to help. It often takes a long wait and the greatest skill on the part of professional counselors and their parent counterparts to help them to begin to make realistic plans for their own child.

Most parents, however, mature quite rapidly under the stimulus of the group. Self-pity fades when they find that they are not alone. Soon they are seeking to learn from and emulate the parents who have met their problems successfully. And before they know it, they are experiencing the healing that goes with helping another family. Some move on to be eager for all parents to have access to the organization which has rescued them from desolation.

Even these mature stage-3 parents can slip back, temporarily, into stage 2, when a problem arises at home or when previous decisions must be reviewed. During these times we can be very difficult. Then you must support us, while feeling "nothing but plain, simple, humble reverence before the mystery of our misfortune," to use the words of John Cowper Powys.[5]

This means that you must look at your own feelings about us and our children. If you do not have a natural feeling of concern for the mentally retarded, if you feel indifferent to or repelled by children who are not mentally normal or by parents under great stress, then you should not be dealing with us at all.

9. *Remember that we are parents and that you are professionals.*

Some of us are becoming so well-informed in certain areas of this problem and we are associating with you in so many different pursuits that, at times, it must be difficult to remember that we *are* parents and, as such, will always be emotionally involved with our own problem and our own child, regardless of the "objectivity" we may have about the problem generally, or another family's problem, specifically. In communicating with us you must be clear as to whether you are speaking as counselor to client, adviser to organization member, coworker, or personal friend. In this we expect you to use professional judgment.

For example, don't in front of us: belittle or countermand the opinion of one of your professional partners; make critical remarks about other parents and their handling of their child; jump to conclusions about our case without adequate clinical study or knowledge of the facts. And, of course, don't try to do a job that is outside your professional discipline.

When we see so much that needs to be done, we have little time for professional jealousies, or for the individual who uses mental retardation as a ladder to personal success. It does not take long for us to pigeonhole a "problem professional" whose own emotional difficulties are getting in the way of our efforts.

10. *Remember the importance of your attitude towards us.*

Sometimes I think your colleagues place too much emphasis on "objectivity" and not enough on "loving kindness." Certainly we expect you to be objective about our problem. But about us? Never! A really gifted professional person cannot *help* feeling—being subjective, attempting to stand in our shoes and to look out at our problem through our eyes—in the process of helping us. Psychiatrists call this "empathy." It is only through empathy that you can divine the proper words and acts to help us.

There are greater depths and breadths in helping parents of retarded children than many of you have realized in your initial attempts. It has been as exciting for some of us parents to watch professionals grow as it has been rewarding for professionals to watch some of us parents grow. We can help each other become more effective people through our partnership.

You are obligated, it seems to me, to "feelingly persuade" us as Shakespeare said, to help us find "what we are." We have many strengths. If you can help us convert our problem into good for mankind, help us find the sweetness in the uses of our adversity, *you* will find a far more precious jewel in your professionalism than you ever thought existed.

And you will be professionals in the most noble and magnificent sense of the word.

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Public-health nurses find new ways of helping mothers through . . .

GROUP DISCUSSION IN A CHILD-HEALTH CONFERENCE

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THE NEED for wider use of group discussion techniques in teaching about health is supported by educational theory which suggests that there can be little education without participation. Therefore, parent discussion groups under the leadership of the public-health nurse are increasingly finding a place in child-health conferences. They emerge from the theory that the basis for information and teaching lies in the shared experiences of the mothers. In fact, workers in public health and health educators across the country are emphasizing the need for more personal and informal contact through group discussion to improve public-health programs.

This paper is a report on the experience of several nurses engaged in a group discussion project in a health agency with a program coordinating the facilities and services of the village, town, and county departments of health. The staff introduced mothers' discussion groups in conjunction with the child-health conference.

For several months prior to starting the group discussions, the staff worked with the mental-health consultant in order to achieve improved interviewing techniques in individual conferences and in field visits. Then the focus of inservice education efforts was broadened to include not only more knowledge and understanding of child development and mother-child relationships but also of group discussion techniques and of their own roles and responsibilities as leaders and group members. The nurses read materials that would help them expand their knowledge of child-health needs, growth patterns, and the emotional concomitants of growth and development. This inservice education program had two purposes: to broaden and strengthen the nurses' knowledge and to help them develop facility in using this knowledge with confidence and skill in the group situation.

Several factors were taken into consideration in organizing the mothers' groups in order to enhance their significance as a learning experience. These included: the organization of the groups; the orientation of the mothers; the care of the children during the discussion; and the provision for continuity between the group discussion and the clinician's service.

The Beginnings

An experimental group of 15 mothers having children of the same age was formed within one child-health conference. The nurses made home visits to let the mothers know about the proposed change from individual conferences to a half-hour group discussion to take place before the children were seen by the clinician. They explained that the change arose from the staff's desire to make the waiting period more profitable for both mother and nurse and to improve the child-health service.

After three sessions, the interest and enthusiasm of the mothers and nurses prompted the incorporation of group discussions into each of the weekly child-health conferences. At present all of the agency's child-health conferences provide for mothers' discussion groups as well as for physical examinations of the child and for individual medical recommendations regarding them.

Some changes were made as a result of the initial experience in an effort to provide an optimum educational experience for the mothers. One involved the care of the children during the discussion period.

The mothers at first met with the public-health nurse in the large waiting room. Half of this room had been set up as a play area for the children, to be supervised by another nurse, thus freeing the mothers but leaving them accessible if need arose for their attention. However, as it turned out there were few separation problems, and the mothers obviously needed a quieter spot for their discussions. Therefore, the discussion group was moved to a smaller room and the entire waiting room left for the children to play in. The chairman of the agency's lay board organized a group of volunteers from the board members and the local Junior League, called play supervisors. The nursing staff outlined the program's objectives for the volunteers and oriented them to their new functions and responsibilities. The board purchased playpens with pads for the toddlers and babies. Books and toys were accumulated for children of various ages.

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At present a public-health nurse with good understanding of child development carries the overall responsibility of the play area and the supervision of the volunteers. This arrangement not only serves the children but offers the nurse a supervisory experience and an opportunity to observe the range of growth and behavior in infants and preschool children.

Experience showed that a half-hour discussion period did not provide the mothers with sufficient time to discuss adequately their ideas and practices. Therefore, a one-hour period was initiated. This has proved to be more satisfactory. After the period is over the clinician sees the mother and child. In some instances the mother may have a postconference interview, usually with the play-area nurse.

The groups are still formed of mothers having children of the same age level. When the mothers and children arrive at the health center they are greeted by a volunteer and given identification tags for the children and their belongings. These help the play supervisor to address each child by his name and to know whether and when a bottle needs to be given. After the mother has prepared the child for her absence, the child remains in the playroom with the play supervisors. However, if separation is a problem the child is allowed to go with the mother.

Content of Discussions

The introduction of the mothers to group conferring is simple and to the point. The nurse explains to each new group that individual conferences have not always seemed productive and have not seemed to meet the mothers' needs; that since the mothers are the persons having experience in rearing children they can help each other by sharing knowledge of what they are doing and exploring new ways of helping their children grow. Then the mothers introduce themselves to one another. Generally they agree that they would like to tell each other about what they are doing. While most of them are not reluctant to talk about their children, some find it hard in the beginning to express themselves, but through the nurse's skill in group leadership are helped to make their comments and contributions. A few are not vocal but indicate their awareness and approval by smiles and nods, and subsequent comment.

Sessions of the established groups begin with mutual greetings among the members and a brief review of previous sessions. In most of the groups the mothers start immediately bringing up their concerns. These include some common areas of interest—eating habits, sleeping habits, toilet training, thumbsucking, pacifiers, addition of new foods, aggressiveness, shyness, discipline, appetites for bizarre foods, bed wetting, spoiling, appropriate

In group discussions, conducted by a public-health nurse, these mothers talk about their common problems and thus learn to understand their children better and help them grow. The meetings are held as part of the weekly child-health conference.

toys, the meaning of play, sibling rivalry, and the father's role.

The leader seldom finds it necessary to initiate discussion. A typical session might start with some of the mothers expressing concern over changing eating patterns in their 2-year-olds—"eating less than he used to," "refuses eggs that she used to like," "gets more on her than in her mouth." The ensuing discussion would center around the lessened food needs at this age, the seeming need to experiment with foods, the importance of weekly or monthly intake, and the permissive or punitive attitudes expressed by the mother around the giving and receiving of food.

Then a mother might voice her concern for her 2-year-old who "will not share any of his toys" and the discussion proceeds: "They are really quite selfish." "With three children one can't afford three of each toy." "What about two girls who are the same age?" "Maybe this is the way they all act, if each child seems to do it." The nurse would lead the discussion into the difficulty in sharing toys, in playing together, and the kinds of imitative play engaged in by 2-year-olds. The session might end with a heated discussion of aggressive play and of children's practice of hitting and biting at this age—very difficult for most mothers to understand and handle in a constructive way. In summarizing the discussion the nurse would offer an opportunity for its continuation at the next group session.

After such a session the mothers frequently make remarks showing what the experience has meant to them: "I feel so much better to know I'm not the only one with problems." "I guess all children are different and can't be treated the same even in the same family." "I can see that my child's feelings are important even at this age." "I guess there is no right way or wrong way; it's an individual thing." "Before, I thought the nurse was only interested in my child; this makes me feel included."

When the discussion period is over the mothers prepare their children for weighing and measuring and for examination by the clinician. By assisting the clinician, the nurse group-leader provides a continuity of service and is able to coordinate what the clinician reports or advises with the concerns the mother may have expressed in the group. The public-health nurse in charge of the play area assumes the responsibility for postconferences, giving the mothers any information needed regarding referrals elsewhere and answering any further questions they might have.

At the completion of the child-health conference, the staff nurses, supervising public-health nurse, mental-health consultant, pediatrician, and visitors meet together to discuss the morning's events. The visitors are usually university students taking their field work with the agency, school nurses, and other nurses from the county staff observing with the idea of instituting group discussions in their own child-health conferences. The purpose is to share knowledge so that each staff member might better meet the needs of the mothers.

The participants in these staff conferences bring in the findings of pertinent reading and study, define mental-health concepts, review their clients' home situations and explore the possibilities of helping with some of the problems of parent-child relationships through home visiting, which is where their interviewing skills are brought into full play. They also discuss their group methods and leadership techniques in an effort to understand the dynamics and improve their skills, the effective use of audio-visual aids, and any additional reference material that might add to their knowledge of both group-work and child health. Through such staff conferences, evaluation and inservice education are continuous.

Some Results

Since this program has been in operation, the nurses have noticed that some changes in relationships have taken place. The mothers are more relaxed and less formal in their approach to the nurse, to each other, and to the clinician. Concerns about their children's behavior which in individual conferences they would not have considered relevant or would have been reluctant to bring up have emerged rather quickly in the group. The permissive atmosphere, the commonality of their concerns and their feeling of status as mothers, and a shift in nurse-mother relationship from authority-client to one of more equality and closeness in purpose have developed.

Formerly there was less socializing in the waiting room than now. The common attitude among the mothers was watchfulness in terms of their child's behavior and its effect on the opinion of others. Talking together about their concerns and practices in raising their children seems to have resulted in the mothers' greater acceptance of each other as people and in being more aware of others and their problems. The pediatrician has also observed that the mothers' behavior in conference with him generally seems to reflect increased self-esteem.

After 6 months of holding mothers' group discussions the staff decided that some concrete material should be obtained to help determine whether or not the needs of the mothers were being met and how the nurse leaders could best proceed. Therefore, a questionnaire was formulated consisting of 15 questions relating to the group discussions. A school nurse temporarily employed during the summer interviewed 21 mothers in their own homes of the total of 79 mothers who had participated in the groups. She was selected on the theory that the mothers might be more frank in answering her questions since they did not know her. Each of the 21 mothers was chosen for interview because she had attended at least four sessions.

Mothers' Opinions

In answer to a question about what they liked about meeting with other mothers, 19 mothers expressed positive feelings and 2 stated that they had no problems to bring to the group. Of these two, one said "Nobody takes my advice." This was the mother who was most negative about the experience. The most frequently cited reasons for positive feelings were: sharing knowledge and discussing common problems; relaxation away from the children; and a better nurse-mother relationship.

Four reasons for disliking the groups were cited in answer to another query. They were: separation from children; monopolizing of the discussion by a few; no provision of a ready answer to a problem; and a preference for individual conferences.

Asked about concerns they would like to talk about, the mothers mentioned: helping children get along with others; feeding; toilet training; discipline; thumbsucking; speech development; and sex education. To a question about whether they had felt free to speak to other mothers about these concerns, 15 mothers answered "yes" stating that in doing so they received new ideas and suggestions, learned about growth and behavior, and obtained greater understanding about the role of the father in family living. Of the 4 who answered "no," 2 said there had not been enough opportunity to talk, one said she needed no help, and one said the group gave no definite answers to her problems. Two mothers left the question unanswered. Another question about freedom to talk brought two negative responses, one attributed to shyness and the other revealing a feeling of rejection because "nobody takes my advice."

Since most of the children were in the playroom during the discussion period, the mothers were asked about their feeling in regard to separation. Eleven mothers had expected from the beginning to leave their child for this period and 4 others had expected to after the first session. The mothers who had expected separation reported that they felt no concern about this, but 2 of the 6 who did not expect it worried about their children's crying.

To a question dealing with the bearing of the time of meeting (sometime between 9 and 11 a. m.) upon attendance, 15 mothers replied that the time was irrelevant, and 6 said it was too early in the morning. When asked if they wanted to get together more often than in their meetings at the child-health conference, 13 replied "no" and 8 replied "yes," but apparently the question was not clear, because they preferred 1 to 2 months as an interval which was the frequency most of them were meeting.

To the question, "Has the group helped you to understand your child?" 19 answered "yes" and 2 answered "no." One of the negative respondents said: "I helped the group." Six said understanding came about through learning from others; 7, through an increased general understanding of growth and behavior; 2, through the opportunity of comparing behavior; 1, through finding an easier way of doing things; and 1, through the films which had been shown to the group. Four gave no definite answer.

Nineteen of the mothers expressed the opinion that group discussion was a good way of learning; one preferred an individual conference; and one did not answer. When asked if they had learned about things they did not previously know, 18 answered "yes," 2 answered "no," and 1 said only that it was difficult to obtain answers to problems from the group.

Another question was: "Do you feel better knowing that other mothers are having the same experience you are?" This led to 19 "yeses" with remarks such as "all in the same boat," "more relaxed," "less worried about what I'm doing." Two "noes" carried no explanation.

Twenty mothers said they felt free to talk to the doctor but 19 of them reported that this was not a new feeling for them. One mother did not answer this question.

The final question asked for suggestions for improving the child-health program. Nineteen mothers had no suggestions. One expressed a preference for individual conferences; another asked for more movies and also suggested that the group complete discussion of one subject before starting a new one.

The results of the questionnaire seem to verify the nurses' impression that the mothers were having a favorable reaction to their group experience—for many, their only group experience. However these results also showed that even in such a small sampling of mothers, there are some who are not comfortable in the group situation, and that therefore group discussions cannot completely take the place of individual conferences.

The discussion groups have continued with some changes which have grown out of experience and the results of the questionnaire. However, the clinic still carries on individual conferences. Many mothers avail themselves of both types of educational opportunity. The groups vary in size from 6 to 12 members. New groups of mothers are formed among those registering with new babies. Occasionally new groups of mothers with older children are also started, but usually newly registered mothers with older children join an existing group.

The mothers' attendance at group meetings and the continuity of their learning experience are based on their attendance at the child-health conference. A nucleus of mothers from each group keep coming regularly over a period of from 4 to 5 years. These mothers get to know one another quite well as their children progress from infancy through the preschool years. The groups meet at intervals of 1 to 3 months, depending on the health supervision needs of the children.

Conclusions

This experience in group education among mothers within a child-health conference setting seems to lead to the following conclusions:

1. Group discussion offers mothers an opportunity for expressing the commonality of parental experience and for sharing their problems, concerns, thoughts, and practices.

2. Active participation helps the mothers to release their feelings and to gain confidence in themselves through mutual support and reassurance.

3. Through their own contributions, the mothers realize the unique individuality of each mother and child and are stimulated to request and accept more knowledge of child growth and development and of the meaning of parent-child relationships.

4. Some questions might be raised regarding the continuity of learning in this project, especially in comparison with groups that meet more frequently. Many community parent-education groups offer a more intensive learning opportunity, but the majority of parents in these groups are not those who use public-health facilities to any great degree. A large segment of the population of many communities are not reached by community educative groups either because of their low economic or social status or their lack of previous experience. Through mothers' discussion groups the child-health conference can offer a dynamic experience within the existing framework of preventive public-health services to a part, at least, of those who are otherwise unreached.

Our experience so far has shown that these mothers are not interested in a more intensive learning experience but prefer to meet within the familiar child-health conference, feeling that it takes time for their children to grow and that since changes occur slowly frequent meetings are not necessary. Possibly this slower process of education carried on over a longer period of time is of real value in meeting the needs of these women.

5. Provision for the care of the children during the sessions allows the mothers to relax and so to participate more actively in the discussion. It also gives the nurses an excellent opportunity to observe child behavior in separation from the mother and in play with other children. Most nurses have had little opportunity to observe well children. This experience can be transferred into a nurse's teaching in all child-health supervision.

An interesting byproduct of the project can be found in the eagerness with which some children approach the health center. The additional help provided by the volunteers has proved most effective in terms of service and community interpretation.

6. The nurses have found this program to be a stimulating and satisfying learning process. The dynamic interaction within the group results in a real expression of the mother's needs, making it possible for the nurse to share her knowledge in terms of those needs. The nurse's presence as a leader helps the mothers feel secure in meeting each other and sharing their mutual interests.

With the universal concern for mental health and improving interpersonal relationships, nurses are increasingly being asked to make concerted efforts toward carrying these responsibilities in community nursing programs. Such efforts require new learnings and new methods in health teaching. Group discussion is an effective way of teaching mothers about important aspects of child health and growth.

Unmarried mothers and social workers express their thoughts on . . .

THE MEANING OF THE MATERNITY HOME

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WHAT MEANING does the maternity-home experience have for the unmarried mother? In an effort to find the answer I recently sent this question to 277 maternity homes and other agencies. Ninety-six agencies in 39 States, Hawaii, District of Columbia, Alaska, and Canada responded—51 maternity homes, 27 family and children's agencies, and 18 State welfare departments. Workers in agencies referring unmarried mothers to maternity homes, workers in the maternity homes, and workers in other agencies talked in staff meetings and interagency conferences about the meaning of a maternity-home experience. Unmarried mothers themselves talked in group sessions and in interviews with caseworkers. Altogether about 100 social workers and 200 unmarried mothers participated informally in the preparation of this paper.

Social workers in 9 of the maternity homes talked with approximately 80 unmarried mothers about the question. Three of these social workers used a simple questionnaire to supplement interviews or group discussion. They contained such questions as: What do you think the maternity-home experience can mean to an unmarried mother? What are you looking for in a maternity home? What can we do so that the experience can have more meaning? Why did you apply for care in a maternity home? What did you think the home would be like? How is the home different from what you expected? What is your opinion about living with a group of girls sharing the same experience? The reply from one maternity home came to me directly from an unmarried mother.

Also included in these findings is material from my own routine interviews with 125 unmarried mothers during several months. I make it a practice in interviews with an applicant or a resident of our home to encourage her to talk about what she is looking for in our service. At the time of discharge I try to get the mother to talk about the experience she has had with us by suggesting that she tell me how she feels about it, what helped her most, what was difficult, and what suggestions she might have for improving the service. During the period of working on the paper, I also had an opportunity to talk with a few unmarried mothers who returned to see me from 6 weeks to a year after living in the home.

The material from the social workers makes clear some have not given enough serious thought to the real meaning of a maternity-home experience. Others are thinking a great deal about what a maternity-home experience does, and can, mean to the unmarried mother, to the caseworker, and to others. All of us need to do much more thinking and much more research, using information coming from the unmarried mother herself, before, during, and after a maternity-home experience, if we are to understand the meaning of such an experience.

Any consideration of this meaning must be colored by the answers to two questions: What maternity

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homes are we talking about? And how do we regard the unmarried mother?

By maternity home, I mean a good maternity home—one having a sound philosophy and clearly stated flexible policies; adequate casework and groupwork with psychiatric and psychological consultation; adequate plant, facilities, and location; provision for adequate medical care; effective public relations and sound financing.

By unmarried mother, I mean a person with all the dignity of human personality who comes to our attention because she is pregnant out of wedlock. I do not mean a category, or a statistic, or a social or psychological phenomenon, or a resource for adoptable babies. I mean a *person.*

I emphasize this because too often we lose sight of the person and her individuality in our preoccupation with the "unmarried mother." She is a person whose psychology must be understood in terms of her early childhood relationships carried over to the present, especially the mother-daughter relationship. Her pregnancy is often a purposive acting out of her inner drives.[1] While some professional workers regard the unmarried mother's pregnancy as a symptom of emotional disorder or disease, Dr. Ner Littner suggests that the pregnancy actually is an evidence of attempted emotional recovery; that is, the best solution the person can find to her emotional dilemma.[2] Whether symptom of emotional disorder, or symptom of emotional recovery, the *person* not the pregnancy is the treatment focus.

What then does, or what can, a good maternity-home experience mean to such a person? What significance do the casework and groupwork services and medical and nursing care have for her in this setting? In studying the data to which I have referred, I find that the meanings center chiefly around three areas:

1. Meanings inherent in "acceptance."
2. Meanings inherent in "shelter," "security," and "protection."
3. Meanings inherent in "group living."

A Place of Acceptance

The material shows that frequently, if not always, all the person pregnant out of wedlock is really consciously looking for is a "place"; a place to get away to, a place to stay in while having a baby because she, and what she has done, are not acceptable in our culture. Tied in with this is her need for secrecy. Sometimes it is not the unmarried mother herself, but rather a parent, or worker, or some other person, who wants her to find a place away from home. Frequently she is seeking a place to go because she is without resources.

The maternity home means such a place, a particular spot. Such practical meanings as a roof over one's head, three good meals a day, a comfortable bed to sleep in, medical care, a doctor, a nurse—are all wrapped up in this "place" to get away to and to stay in.

The person seeking this shelter soon finds that the maternity home—if she is in a good one—is also a place where she is accepted, taken as she is. In fact, she sometimes senses this with the very first touch of the maternity home—the telephone call, the letter, the interview. She knows this not so much by what the maternity-home worker says, as by what the worker *is*—which reveals itself in attitudes and actions. One unmarried mother summed it up in four simple words: "You give me strength."

The importance of such acceptance emerges distinctly from the material. Said one applicant to the maternity home: "I want a place to stay and someone I can depend on." Another unmarried mother, telling of a friend's negative maternity-home experience, said: "The work was hard; the food was poor; you felt you were looked down on; you felt condemned." She added, "Here you feel you're wanted and that you're someone special." The social worker who knew the meaning of being accepted and accepting, said simply and gently, "You are."

Being accepted as a valued person is rarely what the unmarried mother expects. She really expects disapproval and criticism. To the degree that she is truly accepted by the caseworker and other staff members, the maternity home will have positive meaning for her. A month after leaving the maternity home an unmarried mother said, "What I miss most is the attention."

Acceptance rests on the principle of the right of every individual to self-determination and on the belief in the infinite value of human personality. Acceptance means more than taking a person as she is; it means being concerned and caring. Acceptance involves relatedness to a warm person. This relationship is the heart of a maternity-home experience. If a maternity home had no other meaning than a "place" to help the person to experience such a feeling of being accepted, of being wanted, and of belonging, it would be worth a community's investment. But it can, and does, mean more than a place when the acceptance is related to the individual's needs and to total treatment.

A Place of Security

Equally as important as a place of acceptance is the maternity home as a place of security. This is also plainly revealed in the material. Recurring throughout are the words "shelter," "protection," and "security." A close examination indicates that the meaning of all three words is basically the same: freedom from exposure to danger; feeling of, or assurance of, safety or certainty; freedom from anxiety and doubt. It includes not only physical but emotional protection, freedom not only from external but internal pressures. It also includes the need for privacy and confidentiality. These are positive feelings, not to be confused with stifling shelter, patronizing protection, and pseudo-security.

By security I do not mean a wall around an enclosure to separate a person from the world of reality, but rather a bridge between two points—the reality of the present and the reality of the future. This sense of real security for the unmarried mother grows out of acceptance of her as a person in her own right with all the dignity of human personality. It is not a new experience only for girls who come from openly rejecting homes and families. It also has meaning for those who seem to have the support of their families, since somewhere there has been missing in their earlier relationships this sense of being accepted and of belonging.

The material also includes numerous references to the security which comes to the unmarried mother from having good medical care readily accessible.

Acceptance and security take on added meaning in terms of group living. The group in the maternity home, of course, is constantly changing. Moreover, groups, like individuals, vary. Furthermore, there are groups within the larger group. The group may be diversified as to age, education, religion, occupation, and economic and social background. Paradoxically, what the members of the group have in common, in addition to pregnancy, are those traits which create individual differences—human attitudes and feelings.

Group Living

In the material, group living and related factors are mentioned by social workers and unmarried mothers even more frequently than acceptance and security. Some respondents merely mention group living as a positive meaning of a maternity-home experience without analyzing its effect. Others attempt to identify and to define some of the meanings inherent in the experience. These, they find, derive from the fact that while living in a protected community such as a maternity home a person can drop the pretense under which she has been living and face the fact that she is pregnant. Companionship and opportunity to discuss problems with others in the same situation result in less need to deny the pregnancy. Identification with others in the same situation lessens emotional isolation and helps to regain emotional balance.

One group of unmarried mothers was asked directly: "What is your opinion about living with a group of girls sharing the same experience?" Their comments are revealing: "You feel less lonely—less self-conscious—less guilty." . . . "You don't worry as much when you know others have the same trouble." . . . "Everyone is equal." . . . "You realize a lot of things, and you look at the situation in a different light." . . . "I was ashamed when I came. I drew strength from others who seemed to bear up. I was relieved." . . . One girl who had never been away from home before thought it was "fun living with the group"; "it gave me more confidence in myself." Another said it was interesting to hear about the other girls' situations, but she "got tired" of the "same old chatter" about diet, weight, and the like.

The material reveals that reality in group living helps the unmarried mother to face her own reality situation. Learning to understand others and to be comfortable with others, especially those who are different from herself, helps in self-discovery and self-understanding. Learning to accept others as she wants to be accepted is a step in "growing up." Learning to use permissiveness within necessary limitations, where limits make sense and are administered by those who care and are fair, contributes to the development of healthy personality. The chance to live in a warm, happy atmosphere in cheerful and attractive surroundings with people who accept her as she is may be the first constructive relationship she has had, the first healthy parental environment with authority and acceptance. The home's staff members may become "corrected" mother-persons, or unfortunately they, too, may be symbols of inadequate parent-persons. The girl's ego may be strengthened through identification with some staff members who become her ideal. This is revealed in such remarks as, "If I can only some day be half the lady Miss Y. is."

Acceptance and security in group living lessen tensions and help the unmarried mother to relax, thus freeing her to think and to make decisions. Carefully selected work assignments and constructive leisure-time activities give her an opportunity to discover talents and to learn new skills and to share these with others. School opportunities when available enable her to continue her formal education. In those maternity homes where positive religious values are stressed in helping to resolve fears, guilt, and anxiety, and in unifying the whole of living, group living means new spiritual values.

Practicing democracy and learning to accept authority are other aspects of group living mentioned in the material. Commented a young woman of superior intelligence when speaking of the interracial and interfaith aspects of group living, "Why can't the rest of the world learn to live together as we do in the maternity home?"

The extent to which an unmarried mother can involve herself in a responsible way in the give-and-take of group living, with the help of the caseworker and groupworker, determines its meaning for her.

Other Settings

Some social workers regard these same aspects of group living, such as identification, companionship, and discussion with others—particularly about keeping or giving up babies—as reasons for not using a maternity home. Similarly they see the diversity of the group as to age, education, economic and social background, and other factors as negative points in a maternity-home setting. The answer to whether these are positive or negative factors probably depends on the quality of casework available within the maternity home, and how the caseworker helps in sorting out meanings and using the experience in total treatment. This is true especially in relation to the individual who is on the fringe of the group. The material shows that the maternity-home experience could be more meaningful through more and better casework and groupwork and more flexible policies regarding time of admission, length of stay, visiting and other privileges, and a more enriched program.

A place of acceptance, a place of security, a place of growing up in healthy group living—are these meanings limited to a good maternity-home experience? Are these meanings always found in a good maternity home? Of course not. Can't the person experience these meanings in other settings? Why not? This article is not intended in any way to be a discussion of maternity homes in contrast to boarding homes or foster homes or wage homes or independent arrangements in rooming houses and apartments.

Whether to use the maternity home, or some other living arrangement for the person pregnant out of wedlock, depends on the resources available, the dynamics of the person needing service, and the skill of the caseworker in helping that person to determine what resources she wants and can use. It is interesting to note that in the material from social workers the same reasons are frequently given for choosing either a maternity home or a boarding home. The caseworker with her knowledge and skill and warmth helps the person to determine what she is looking for and to make the maximum use of the service available to meet her needs.

In the final analysis, I believe, the constructive use of a maternity-home experience revolves around the caseworker and other staff members who accept the person pregnant out of wedlock and are able to give of themselves fully in meaningful relationships to help her move toward more maturity. Given such caseworkers and other personnel in the maternity home and in the other community agencies, the maternity home can have much meaning in treatment.

Only with more diagnostic material and more valid histories can we more adequately identify, define, and evaluate deeper meanings and their relationship to total treatment. Until then, those of us who have the privilege and responsibility of offering maternity-home service can continue to increase our knowledge and skill to make the maternity home a place of acceptance, of security, of healthy group living. Such an experience can contribute to the well-being of the whole person, making it possible for the unmarried mother to say, as one respondent said: "Now I am well and ready to face life with my chin up."

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[1] Young, Leontine: Out of wedlock. New York: McGraw-Hill, 1954.

[2] Littner, Dr. Ner: The natural parent. Paper presented at the National Conference on Adoption, sponsored by the Child Welfare League of America, January 26–29, 1955.

Neglectful parents can often become good parents when their strengths are developed. Missouri helps them to do this through . . .

PROTECTIVE CASEWORK SERVICE

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ALL ACROSS THE COUNTRY today aroused communities are initiating action to control and prevent juvenile delinquency. If their programs are to be effective, however, they must give increased attention to the provision of protective services to children in their own homes. In the broadest connotation such protective services include a variety of environmental and therapeutic services to safeguard the physical, mental, and emotional health of children, and to insure their well-being. Important among them is protective casework service—a direct casework service to parents not requesting help on behalf of their children who are not receiving minimum standards of care as determined by the community.

We know that a child has his best chance for physical, mental, and emotional growth and development by living with his own parents if they are reasonably mature, warm, and affectionate, physically healthy, and understanding of his needs.[1] We know too that not all parents can provide this opportunity to their children.

In 1943 the Child Welfare League of America published a report which constituted a survey of voluntary and public agencies giving protective services.[2] The survey showed there were "*greatly differing definitions of protective services which affected the intake and approach to families.*" The report could find no common ground in method other than "skills in protective services are drawn from generic casework supplemented by psychiatric knowledge." It concluded that "protective casework service is initiated when the community expresses concern for the welfare of a child."

Eleven years after the initial Child Welfare League study we still do not know the extent of protective casework service in practice. and there continues to be some division of opinion regarding the method of giving the service. For every year that passes in failure to provide protective casework services, more and more children will need care outside of their own homes. If we are not concerned about the mounting costs of such care then surely we must be concerned for what happens to the child in separation. Even at its best, it leaves its mark on his personality development. There is no question that protective casework service is both economically sound for the taxpayer and emotionally sound for the child and his parents.

Those who are engaged in protective casework services have a responsibility for defining their methods. They must do this in order to have a measurable service that can be evaluated and reevaluated qualitatively as well as quantitatively.

Authority

Social agencies give protective services when they have a legal mandate or administrative policy, emanating from the board or the law, or both, *to protect children.* This carries with it a right to offer unsought help. Social workers in such agencies carry two types of authority: that which the community gives in law or board policy or both, and an *inherent authority* which is derived from their profession in being casework practitioners. They do not have the same authority as the judicial agency, which they sometimes may need to call upon in planning for the child.

The caseworker's authority is not dangerous if she is not afraid of it. In order to use it constructively, she has to examine her own reaction to authority. Sometimes the workers most afraid to use it are unconsciously the most authoritarian people. The caseworker must also look into her own feelings to learn why it might be painful for her to help a parent who does not want help.

Getting the right feel about protective casework service is not easy. For the caseworker to know what she is there for and be comfortable about it is a good beginning. Being self-analytic sometimes brings discomfort, of course, but social workers are in a profession where practitioners often grow and mature through periods of discomfort. The satisfaction of helping parents to become better parents and the resultant satisfaction the parents achieve in parental privilege and responsibility are worthwhile goals.

The remainder of this article describes protective casework as practiced in the Division of Welfare of the Missouri Department of Public Health and Welfare.

Complaints

A protective agency first learns about the child's not getting minimum care from a complaint to this effect. The complainant may be anyone—a parent who is no longer a member of the family group, a relative, a neighbor, the county commissioners, the district attorney, the judge, a teacher, a nurse, a minister, a member of the agency's staff, another agency, or it may be read in or between the lines of an ADC case record.

However, agency policy determines from what source complaints will be received. For example some agencies accept complaints only from the juvenile court. In Missouri the Division of Welfare accepts all cases referred to it by the juvenile court as well as complaints from individuals in regard to families receiving public assistance.

In this way the agency knows that a child, or children: (1) lacks physical or health care; (2) is physically abused; (3) is exploited; (4) is exposed to an undesirable environment or association; (5) is without proper supervision from a responsible adult; (6) is so emotionally deprived that he has developed behavior symptoms. The agency also learns from the complaint that the parents have failed to do anything to remedy the situation.

It is very important for the caseworker to have specific information regarding the parents' failure to provide proper care for the child, as a basis for frank discussion. It is not enough for her to say to the parent: "We have been told that you are neglecting your children and we are here to help you give them better care." This confuses the parent. The caseworker must begin with specifics such as: "We learned," through whatever source, "that you spent the last two weekends out of town and that the children were at home with no one to look after them. The complainant also tells us that the children are truant from school, and that you sometimes don't know what you are doing when drinking and whip the children severely with a strap."

It is necessary for the caseworker to have a valid and well-supported reason for entering the picture. The complainant must provide the proof that minimum standards are not being met and tell of the circumstances surrounding these conditions. It makes a difference if the complainant is judging lack of minimum standards of care from his own rather than the community's standard. If this is so, the agency tells him that service is given only if the community standard of care is unmet. In dealing with complainants the agency recognizes their genuine concern, helps them be specific about their complaints, explains its services and exhibits its own concern and sense of responsibility for the child.

When the complainant is another agency, that agency has a responsibility to tell the client that the complaint is being made.

When the client is told about the complaint treatment has begun, for the complaint challenges the parent to change. Treatment in social casework is composed of challenge and support constructively used and perfectly timed. In beginning with the complaint, the caseworker not only stirs the parent toward change, but also gives understanding and support.

When one parent living with the family makes a complaint about the other parent it is important for the caseworker to engage the complaining parent at once. Both parents are equally responsible for their children and thus both parents are responsible if one parent fails to give minimum care. The social worker can ask the complaining parent what he has done to help change the situation, thus stirring him to responsible action.

Too often in protective casework we forget the fathers and deal solely with the mothers. Both fathers and mothers are important. The caseworker may want to interview them together or separately depending on the situation, but she must get over to them the togetherness of their responsibility in parenthood.

Initiation of Service

If social casework is to be meaningful, it must have focus and direction. The object of protective casework is the child, but the focus is on the parent—as a person, and as a parent. The concern is for the person, but the focus of treatment is on the parent part of the person. The caseworker begins with the symptoms which show the client's shortcomings as a parent, not as a person. If a neurotic mother rejects her child to the extent that he develops behavior symptoms the casework focus is on what the mother does with the child. The caseworker's purpose and goal in dealing with the mother is not to treat her neurosis but to help her become a more responsible parent.

When possible, service is best initiated through a letter to the parents identifying the agency and the caseworker, pointing to the community's and the agency's concern for the child, and calling the parents' attention to the fact they are not meeting minimum standards of care and inviting them to the office for an appointment.

The letter serves several purposes. It (1) identifies the agency; (2) gives a general explanation of the service and the community's concern; (3) introduces the reality that help is needed; (4) gives the parent a chance to react in privacy; (5) provides a means for stirring the parents; (6) gives the parents time to consider what to do.

The parent is offered an office appointment because this is usually less threatening than a home visit. The office interview gives him a chance to take the first forward step toward change. However, if it is physically or emotionally impossible for the parent or parents to get to the office, the caseworker visits the home after writing a letter to say she is coming.

If following a careful diagnosis and interpretation of casework services to the parents, the parents indicate that they do not want the service and cannot utilize it, the agency has no other recourse but to withdraw. If minimum care is not being given to the child and the limitations of the home for the child outweigh its strengths, the situation has to be referred to the juvenile court for legal action.

Time is a precious tool in casework. It is important that worker and parent talk over the time they will spend together. This setting of interviewing time, place and frequency is done in the first interview, and is arrived at mutually. The caseworker may ask the parent: "How long do you think it will take for you to change the conditions that led to the complaint? Do you suppose that we can try this interviewing schedule, and in 3 months see how much has been accomplished?" It is essential that the caseworker periodically reevaluate the situation with her supervisor.

Relationship

Worker-parent relationship is the *most* important tool in protective casework services. In order to build a purposeful relationship the caseworker has to believe strongly that nearly all parents want to be good parents. She must know that in every human there is a "core of positives" that, if stimulated, helps him to achieve. She must believe deeply that people have the capacity to change, to develop, and to evolve.

Believing this with all her being as well as with her intellect, the caseworker then offers parents: warmth and kindliness; understanding and acceptance as persons; respect for their individuality and personal dignity; outgoingness; strength and vigor; and hopefulness.

Although the caseworker gives parents understanding and acceptance as persons, she does not condone their behavior in respect to their children. In fact, she says, feels, and acts out—"I understand you, like you, accept you, know that you want to do the right thing for your child, if you could. I respect your individual dignity as a person; but I, as a representative of the community's concern for children, cannot accept what you do to your child."

To verbalize or accept this intellectually is not enough. The successful worker in protective casework service has to feel this and emanate this from her entire being. Only in this way can she truly accept the parent, regardless of the kind of care he gives the child. Only then can she help parents to take steps toward making outward or inward changes for the sake of their child. She must be aware that the parents themselves may have been denied adequate care and emotional acceptance.

Treatment

Treatment takes place through interviews in which the parents' problems, fears, and conflicts in relation to their child are discussed. It takes effect when the parents can accept the worker's, the agency's, and eventually the community's standard of child care. Neglectful parents are often hostile. Having often received rebuffs because of their behavior they react hostilely. They often expect hostility and if they don't receive it, their fears on which their own hostility is based are diminished.

Often the caseworker may have to become the good parent to the parent. When such a relationship is used the caseworker must be alert to step out of the parent role as soon as possible to avoid perpetuating the dependency relationship too long. The good parent is nonsubmissive, nonjudgmental, and is kindly, firm, and consistent. A good parent is supporting, but not too supporting. He sets limits of unacceptable behavior. He is firm, but he controls his own hostility. He expects growth and self-reliance. The good parent-therapist helps the parent see and face facts and issues, and helps him to see choices and alternatives. Treatment is a corrective emotional experience and it is often a slow processs.

Protective casework service begins with a consideration of specific facts showing the parents' deviation from the average of accepted parenthood, as the community sees it. These facts come from: the complaint; subsequent exploration; and an evaluation of the parents' previous experience with social agencies, if any. In considering this last it is important to learn: whether the parents were able to relate to the other agency constructively; whether they were able to use its services; what length of time they needed financial assistance or service; and whether they revealed any positive factors, such as strong family feeling, ability to focus on the problems and to understand their relation to their past, a desire for change, and ability to be self-responsible.

This other agency's evaluation gives some clue as to how a parent may use his experience with the agency. Even though the other agency arrived at a poor prognosis the caseworker continues to try. She does this because she knows that she has had success with some parents who were not able to use other agencies. She knows that the focus of the other agency may not have centered on responsible parenthood.

The caseworker gets her direction by listening to what the parent says. She lets the parent tell about himself, helping him to focus on the relation of his own history to his lack in parenthood. She is not interested in history for history's sake. She is interested in history if the client has a need to share his past, but she does not let the needle get stuck in the same groove. If a mother says that she cannot be a responsible mother because she never knew what it was to have a mother, the caseworker listens, understands, accepts the fact, identifies with it, but brings the mother back to the reality of the task before her—learning to be a responsible mother. She remains a reminder of the ever-present reality factor for the parent.

Steps and Goals

In treatment, the goals must be based in reality. The caseworker is not treating the total personality of the parent. She is focusing on the parent part of him and his potential for changing this.

From the parent the caseworker gets the clues for the steps the parent will need to take in correcting the situation. She begins where the parent is, not where she the caseworker is or where she would like the parent to be. She helps him sort and decide on alternatives in action. She talks about the down-to-earth specifics of the everyday business of parenthood.

The caseworker does not set the goals for the parent. The parent sets them for himself with the aid of the caseworker's challenge and stimulation. She helps him to decide on what conditions are good and right for his children. She helps him take the smallest step he can toward this. She shows her faith and confidence in him. She continues to widen his capacity by arousing his confidence in himself and stimulating his initiative.

In a certain rural county there were 12 children with a mother who appeared to be mentally limited. The father was intelligent and worked when he could. The case was referred by a nurse, public-health committee, neighbors, and public-assistance worker. The children were truant from school, the house was filthy. Every agency in the county had been in on the case in the past 10 years.

Father's weekly interviews were productive. Mother's separate weekly interviews were not as productive. Father thought the house and children could get cleaned up if they had water in the home. The caseworker asked him how to get water. Father said: "Dig a well." The worker said: "Who will dig it?" Father said he would dig it if someone would pay for the necessary equipment. The caseworker got the Farm Bureau consultation and community groups to pay for the equipment. Father dug. Step number 1 was taken with resultant satisfaction to father and mother. The children were cleaned up, and the community began to have more confidence in the parents.

The caseworker praises and encourages the parents for each step they take, stimulating self-satisfaction in their accomplishments. They begin to take pride and joy in being acceptable parents and often come to the interviews looking better, feeling better, and being better. The caseworker thinks, feels, and says: "I do have confidence in your ability to change; look what you have done. That is good. That is fine."

As caseworker and parent work together, the caseworker stimulates the parent to a conscious evaluation of his job of parenthood. She focuses on "what is it that is causing this difficulty in being a responsible parent?" rather than on "why aren't you a responsible parent?" When the parent has discovered what it is that keeps him from giving minimum care, and what he can do about it, he has developed some insight into his unconscious motivation, and can set up controls to help him cope with the difficulty.

Termination

The agency terminates a protective service case when:

1. Change in the situation has taken place and the child is receiving care which is at least up to the community's minimum standards.
2. The service has been given for a period of time (12 to 18 months) and though little change has taken place the positive strengths of the parents in parenthood outweigh the negative factors.
3. After a period of time (varying with the situation) change has not taken place and the child's welfare is in danger. At this point the agency has no alternative except to go to the juvenile court. The court may ask the agency to continue service, or occasionally when it seems that bringing the case to court may help the parents face reality, the agency may recommend continued service to the parents through court action, or the court may place the children.
4. After a period of working together when the parent voluntarily requests placement and this appears to be for the best interest of the child and of the parents.

What goes into the decision to terminate a case? Termination really begins at the beginning in the caseworker's initial evaluation of the parent's capacity for parenthood and continues with parent participation. Directly or indirectly the caseworker continuously asks: What are your strengths? What are your capacities? Can we get to the positives in your potentialities? What steps can you take? What steps have you taken? How far have you come from those ways in which you were failing to provide minimum care?

The clues for termination must come from the parent as the case proceeds. These are indicated by the constructive changes he makes in his ways of providing care and by his increasing satisfaction in the job of parenthood. There are clues in such remarks as: "When I think of how upset and nervous I used to get 3 months ago when Nan and Pat got into a fight, and how calm and really helpful to them I am now" or "The housekeeping was always drudgery, but now it's worth it."

If the caseworker keeps the case open longer than necessary, she really denies that she believes the parent has capacity and that change has taken place. Thus she may add to self doubts which the parent has about his ability to be a responsible parent. The aim is not to be a continuing supporting factor for the parent but to help the parent develop his innate capacity, out of his core of positives, toward satisfying responsible parenthood.

In Summary

Protective casework is based on the premise that most parents want to be good parents, even if they are failing miserably. It means a great deal of understanding of what causes them to behave as they do; and what factors both outside and inside of themselves make them neglect their children. It means looking for the smallest ray of hope—the minutest positive in parenthood on which to build. It means tapering great expectations to fit the individual parent, which may turn out to be small expectations. It means genuine, heartfelt acceptance of the dignity and worth of the individual parent. It means acceptance of him as a person; but it does not mean condoning his behavior as a parent.

Protective casework requires a realistic redefinition of "the right of self determination," as applied to the parent. Can society afford to let a parent be self-directing, without help, if this self-direction interferes with the minimum standards of care every child needs for development toward eventual happy and responsible adulthood? Is it true that in life it is necessary to give up some measure of freedom to attain a greater and wider freedom? Do we really believe people have a capacity for flexing and changing? Such questions reveal the tremendous burden of responsibility on those social workers who by the very nature of their jobs may be required by law or agency policy, or both, to assist in the maintenance of the family unit for the protection of the child.

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[1] Bowlby, John: Maternal care and mental health. New York: Columbia University Press, 1951.

[2] Conferences on Protective Services Held in 1942. Child Welfare League of America. 1943.

A MILESTONE IN EDUCATION FOR SOCIAL WORK

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EDUCATION for any of the professions has developed largely by the trial-and-error efforts of those practitioners who have had the zeal to impart some of the knowledge and skill they have acquired by experience. Traditionally, professional schools have frowned upon anyone teaching who has not first practiced with some degree of success. Similarly, education for social work has developed its standards through the leadership of practitioners who could apply to students some of the understanding of individual growth and development that they have made use of in service to clients.

Too much teaching in this field, however, is intuitive or patterned after teachers who have made an impression upon the person teaching.

The publication of Charlotte Towle's "The Learner in Education for the Professions"[1] marks a milestone for professional education as such. Here are gathered together the wisdom that comes only from experience and a body of principles that come from study, analysis, and generalization. Miss Towle has distilled from her experience as a practitioner and teacher of psychoanalytically oriented social casework those principles of learning which give maximum consideration to the capacity and movement of the learner. To these she has added the benefits of a lifelong study of education which began as an undergraduate student and was continued in collaboration with colleagues on the University of Chicago campus. All this has enabled her to generalize about principles of education in any profession, and specifically in social work, especially social casework.

To the educator an exciting aspect of Miss Towle's book is its affirmation of what one has learned from experience. It would be reassuring if it did no more than show the universality of the "curve of learning": the plateaus and slumps that students experience with the subsequent spurt in achievement; the struggle that most students have as they let go of the old and take on the new under stress of growing self-awareness and insight; the preoccupation with self-activity that precedes ability to focus on the client and his activity.

Miss Towle's contribution is in underpinning these and other phenomena with a theoretical base about learning and with a body of generalizations about teaching. Although social casework is the part of the curriculum to which she applies these processes, the principles are relevant for all of education for social work and even for other professions. This is one of those all too rare books that integrate theory and practice.

The book is divided into two parts. Part I, on "Learning Process and Educational Process," lays the foundation for Part II, "Applications in Teaching Social Casework." No condensation of content could reveal the wealth of material presented. Therefore, only a few aspects will be commented on here.

Student Selection

Today when applications to schools of social work are dropping, the selection of students is a critical problem. Miss Towle refers in many places to the need for "socially educable" students and devotes chapter 6 to selection. She points out that social work makes heavy demands on the learner to change, to relate to others, and to become able to function independently within the framework set by the profession.

It is true that criteria for educability are still tentative, but we have learned a few things. Good intellectual capacity is fundamental for learning but high-grade point average alone does not provide evidence that the student is socially educable. The self-centered or neurotically inhibited student may compensate for social immaturity by concentrating on intellectual achievement. Too great deprivation in early life and no experience of a close relationship of mutual trust with another make a candidate a poor risk for a profession in which faith in another and ability to enter into close association with him are essential.

One can only agree with Miss Towle that we know more about the problematic learner than we do about the normal or highly productive one and that "potentials for growth and change as the individual is nurtured through a desired experience are not readily known out of context of the experience." But at this time when so many professions and trades are competing for the college graduate, schools of social work need to continue with more care than usual to study criteria for the socially educable lest they bring into the profession persons who are inadequately prepared or motivated to carry the responsibilities which are required. Admissions committees of schools of social work and agencies employing untrained workers would do well to read chapter 3, "Personality Development."

To help a student learn with due regard to his motivation and capacity is, of course, the aim of the teacher. How to do this is less obvious. Miss Towle has provided many leads in her discussion of "Educational Principles and Process" (ch. 5). Among them are: (1) individualization of the learner so that he learns with his "ego intact," with reorganization and integration, without disorganization; (2) provision of knowledge as a basis for doing—*to know* comes first; (3) arrangement of learning experiences so that they have continuity, sequence, and integration; and finally, (4) an educational relationship that sustains the student as he struggles to acquire knowledge and to discipline feelings related to it.

The book stresses the importance of distinguishing between therapy and education. Just as the student must learn the limits of his service to the client, so the educator must distinguish between those problems of learning for which it is his responsibility to provide help and those problems within the student's personality which call for help from another kind of specialist. While the relationship of the student is probably closest to the field-work supervisor and the faculty adviser, Miss Towle makes the point that the total educational experience must be a positive and supporting one. The student has multiple relationships—to individual instructors, to the administrative officials of the school, to his fellow students. If all of these relationships confirm and reinforce one another, his learning is greatly facilitated.

Principles and Application

There will doubtless be less widespread agreement about the applications of principles to teaching presented in Part II of the book than about the principles themselves. Here Miss Towle relies upon her experience in one school of social work. For example, while she concedes that social groupwork is "another treatment process" alongside social casework, she regards community organization as a part of the "organization and administration of welfare services" rather than as an aspect of "social treatment."

A contrary point of view would distinguish social community-organization work as a method from the field of community organization for social welfare. This approach would perceive patterns of behavior in the social institutions and resources which people develop and in the attitudes which they hold in common, and would assert that the social worker's function is working with people in their organized relationships to help them modify attitudes and resources and to create new ones. Whether designated as casework, groupwork, or community organization, social work is concerned with help to people in their problem-ssolving needs. The ends are products of the means whether the work is with intergroups, with primary groups, or with individuals.

One other criticism, which Miss Towle foresaw, is the amount of repetition that is occasioned by the book's organization as a collection of papers, each of which can be read alone, with the exception of three chapters. Perhaps Miss Towle's opinion that learning requires repetition may have affected its composition. While the reiteration enhances the reference value of the book it detracts from its readability as a whole.

Miss Towle has done a great service to professional education in making available her rich store of knowledge about its theory and practice.

With this book, we move ahead in social-work education.

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[1] Towle, Charlotte: Learner in education for the professions. Chicago. University of Chicago Press. 1954. 432 pp. $7.50.

BOOK NOTES

STUTTERING IN CHILDREN AND ADULTS; 30 years of research at the University of Iowa. Edited by Wendell Johnson, assisted by Ralph R. Leutenegger. University of Minnesota Press, Minneapolis. 1955. 472 pp. $5.

Addressed to speech pathologists, psychologists, special-education supervisors, physicians, and other professional workers and students, this collection includes more than 40 reports of research on stuttering.

The reports offer the results of study of a number of facets of the subject, such as the onset of stuttering, nonfluency of speech in stuttering and nonstuttering children, conditions under which stuttering varies in severity; personal adjustment of stutterers, physical approaches to stuttering, and therapy.

The most inclusive chapter discusses the relationship of parental attitudes and adjustments to the development of stuttering. In this connection, the editor of the book remarks that the problem of stuttering seems to start, not in the speaker's mouth, but in the ear of the parent or other authoritative listener.

THE DYNAMICS OF CASEWORK AND COUNSELING. Herbert H. Aptekar. Houghton Mifflin Co., New York. 1955. 262 pp. $3.50.

In this book the author presents an approach to casework theory and practice which he believes integrates what are usually regarded as the two opposing theories of the diagnostic and functional schools of thought and practice. Explaining their origins and basic concepts, he suggests ways of combining the positives of each into a *dynamic* approach to casework and counseling. In doing so he presents and analyzes a tape recording of an interview in which such an approach has been used. The book concludes with a call for more "inductive research" carried out through similar analyses of cases from both diagnostic and functional schools in order to find out what caseworkers are actually doing. Social casework, the author maintains, will not be really mature until the two schools of thought have become integrated into a truly dynamic concept focused on "change which produces change."

The book carries a brief introduction by Marion Hathway, its editor. The author's acknowledgments suggest that the manuscript was reviewed by a broad representation of social casework theoreticians and educators.

AMERICAN INDIAN AND WHITE CHILDREN; a sociopsychological investigation. Robert J. Havighurst and Bernice L. Neugarten. University of Chicago Press, Chicago. 1955. 335 pp. $5.

Nearly a thousand children were studied by the authors with two major purposes: to find out as much as possible about their moral and emotional development and to devise a battery of tests which might be used by other workers in similar cultural studies. The report shows the results of tests given to six groups of Indian children—Hopi, Zuni, Navaho, Papago, and Sioux—and to a group of white children living in a typical Midwestern community.

An appendix compares the findings on the Midwestern white children with information obtained about 1,700 New Zealand children similarly tested.

The study was undertaken as part of the Indian Education Project of the Committee on Human Development, of the University of Chicago and the U. S. Department of the Interior's Office of Indian Affairs.

HEARING THERAPY FOR CHILDREN. Alice Streng, M. S.,; Waring J. Fitch, M. D.; LeRoy D. Hedgecock, Ph. D.; James W. Phillips, M. D.; James A. Carrell, Ph. D. Grune & Stratton, New York. 1955. 371 pp. $6.75.

To help members of professional groups who work with children handicapped by loss of hearing, the authors present information on causes of hearing losses and their medical treatment; case finding, clinical audiometry; hearing aids; and education of children with different amounts of hearing loss. An appendix lists established hearing rehabilitation centers in the various States.

CHILD DRAMA. Peter Slade. Foreword by Dame Sybil Thorndike. Philosophical Library, New York. 1955. 379 pp. $10.

Emphasizing that *drama* is "what you do," as opposed to *theater*, which has come to mean "what you sit and watch others do," the author of this book shows how child drama, born of play, "can be nurtured, guided, and provided for by the wise parent and the able teacher."

The book offers practical suggestions for encouraging spontaneous drama—including art and music—among children from infancy through the age of 15. Though much of the book is addressed to teachers, the author makes clear that child drama outside of school is just as important as it is in school.

SPECIAL EDUCATION FOR THE EXCEPTIONAL. Merle E. Frampton and Elena D. Gall, editors. Porter Sargent, Boston. 1955. Three volumes: Vol. 1, Introduction and Problems, 453 pp.; Vol. 2, Physically Handicapped and Special Health Problems, 677 pp.; Vol. 3, Mental and Emotional Deviates and Special Problems, 700 pp. $5.50 per volume.

Planned as an introduction to the field of services for exceptional children and adults, these three volumes offer a description of such services, with emphasis on education, and many references for further study.

Volume 1 discusses the general field of special education and summarizes problems and methods common to all its phases. Volume 2 focuses on the physically handicapped—those with defects of sight, hearing, and speech; the orthopedically crippled; those with heart disease or rheumatic fever, Hansen's disease, muscular dystrophy, or tuberculosis; and those with multiple handicaps. It includes material on the homebound and the hospitalized. Volume 3 treats the subject in relation to the neurologically impaired, the epileptic, the emotionally disturbed, and the mentally handicapped. It also discusses the intellectually gifted.

PROJECTS AND PROGRESS

The Polio Vaccine

Although less than 9 months have elapsed since the effectiveness of the Salk poliomyelitis vaccine was first announced, more than 10 million children and expectant mothers have already received vaccinations, and organized programs for giving the vaccine on a priority basis are now operating in 54 States and Territories.

Preliminary reports on the effectiveness of the vaccine, based for the most part on children who had received only one injection, indicate that the attack rate of paralytic polio among the unvaccinated is two to five times greater than among the vaccinated. Even more encouraging results are expected as children receive the full dosage of three injections. All States and Territories and more than 40 virus laboratories are cooperating with the Poliomyelitis Surveillance Unit of the Public Health Service in conducting these evaluation studies.

Progress of the program has been somewhat handicapped by limited supplies of vaccine and by the tragic aftermath of two early defective lots. However, improvements in testing methods, which were first revised in May and again in November, now assure consistent production of safe vaccine.

Except for a small amount of vaccine which was distributed commercially, all of the early supplies were channeled to the National Foundation for Infantile Paralysis, which offered to provide two injections, free of charge, to all children who were in first and second grades in the spring of 1955. By late fall, this program was virtually completed, with almost 7 million children—three-fourths of all who were eligible—participating.

Plans for providing vaccine for the most susceptible groups who were not covered by the National Foundation program were launched last April, when a National Advisory Committee on Poliomyelitis Vaccine was appointed by the Secretary of the Department of Health, Education, and Welfare. Comprised of representatives of the medical and public-health professions, the drug industry, and the public, the Committee developed a voluntary-control system under which all vaccine, other than that used by the NFIP, is distributed to the States.

Under this system, a priority group is recommended by the National Committee and each producer agrees to ship into each State that proportion of each release of vaccine which corresponds to the proportion of unvaccinated persons in the priority group residing in the State. The allocation is made by the Public Health Service on the basis of data furnished by the vaccine manufacturers and by the States.

Distribution within each State is planned by the State health department in cooperation with a State advisory committee. Each State decides how much of its vaccine will be distributed through normal commercial channels to physicians and how much will be reserved for public agencies. Each State also decides what groups will have priority. Most States follow the National Committee's recommendation on priority, which was originally limited to children aged 5 through 9 but was expanded in October to include all children under 15 and expectant mothers.

To help States finance poliomyelitis-vaccination programs, Congress passed the Poliomyelitis Vaccination Assistance Act on August 12. This authorized grants to States for purchase of vaccine and administration of programs. Out of the initial appropriation of $30 million, $25 million was earmarked for purchase of vaccine and about $5 million could be used either for vaccine or for administrative costs. In addition $4.5 million of the general health-grant appropriation was earmarked for administration of polio programs.

By the middle of November, 54 States and Territories had applied for vaccine grants and were operating under plans approved by the Public Health Service. To meet Federal requirements, these plans provide that the vaccine will be used only for children under 20 and expectant mothers and that, in public programs, no means test will be used to limit eligibility.

Most States depend on local communities to develop detailed plans for use of the vaccine. The prevailing pattern is to make the publicly purchased vaccine available both to private physicians (who may charge for services) and to public clinics (where both vaccine and service are free). In a few States all vaccine is purchased with public funds; in some others, no publicly purchased vaccine is distributed to private physicians; but in most States, private physicians can obtain vaccine from both commercial and public sources.

Shortage of vaccine is now the major obstacle to mass vaccinations. A proposal to stretch the supply by limiting each eligible person to one injection of one cubic centimeter was considered in December by a group of medical and public health authorities called together by the Surgeon General of the Public Health Service. The proposal was rejected, however, on the grounds that the immunity one injection provided might not last through the next polio season.

The schedule unanimously endorsed by the group calls for two injections of one cubic centimeter each, the second following 4 to 6 weeks after the initial dose (or as soon thereafter as possible). Seven or more months later, a third "booster" shot should be given.

Crippled Children

About 3,000 persons with cerebral palsy received services from 165 public or voluntary agencies—medical, educational, or social—in New York City in 1954, according to the Coordinating Council for Cerebral Palsy, a local voluntary agency. An additional 103 agencies offered such services, but had not served any cerebral-palsied persons during the year of the survey. The largest number of persons were served by public agencies—the city department of health and board of education and the State department of education.

While the total number of cerebral-palsied persons in the city is not known, the city health department's bureau of handicapped children estimates the figure at 12,000 to 19,000. The Council recommends that efforts be continued to establish an unduplicated register of the cerebral-palsied to help in planning services.

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The Welfare and Health Council of New York City, with the help of the Association for the Aid of Crippled Children, has begun a 3-year research study to demonstrate how handicapped and nonhandicapped children and youth can be helped to engage in joint activities in community centers, settlements, and camps.

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Special rheumatic-fever and cardiac clinics are carried on in more than 600 communities in the United States, representing about 90 percent of the population of the country. More than half the clinics are sponsored by official agencies.

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Ohio's State Legislature recently rescinded a requirement that a court commitment was necessary before a child could receive services under the crippled children's program. Ten States still have such a requirement.

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The American Public Health Association's Committee on Child Health is issuing a series of guides for agencies and organizations concerned with community services for children with various handicaps. The first of the series, entitled "Services for Handicapped Children," sets forth general principles and practices. The others, some already published, will illustrate their application in planning services for children with specific disabilities. These include: cerebral palsy, cleft lip and cleft palate, dentofacial handicaps, diabetes, emotional disturbances, epilepsy, hearing impairment, heart disease and rheumatic fever, orthopedic and neuromuscular handicaps, and visual impairment and other eye problems.

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After a child has passed the acute phase of rheumatic fever his own home is in most instances a good place for him if housing and nutrition are adequate, the emotional atmosphere is favorable, and community agencies are available to provide the services he needs, according to "Standards for General Convalescent Homes Caring for Cardiac Children," a 20-page guide to communities planning convalescent-care programs, recently issued by the American Heart Association. While it outlines the essentials of a well-rounded program for a convalescent home, the guide advocates a review of total community resources and needs before planning to build such a home, particularly in view of the fact that the incidence of rheumatic fever is decreasing. Available to professional persons on request, from the Association, 44 East 23d Street, New York 10, N. Y.

United Nations Action

At its last meeting the General Assembly of the United Nations increased the funds available for the program of advisory social-welfare services to governments for 1956 and the following years. The amount voted was $1 million.

The action was taken at the suggestion of the Economic and Social Council, on recommendation of the Council's Social Commission, for providing a significant increase in resources for these services.

The Council has also approved the Commission's recommendation that a small group of experts be established to study maintenance of family levels of living through social insurance, social assistance, and related social services. Another of the Commission's approved recommendations suggests that official and voluntary agencies in member nations increase training facilities and programs for social workers.

The Secretary-General of the United Nations recently reported that between 1950 and 1954 the number of schools of social work throughout the world increased from 335 to 432.

World Health

As a step toward eradicating malaria from the Western Hemisphere, a coordinating office for various governments' malaria programs has been established by the Pan American Sanitary Bureau, the World Health Organization's regional office for the Americas, with headquarters at Mexico City. The governments are emphasizing the necessity of attacking the malaria-carrying mosquito, anopheles, on a broad front before it develops resistance to such insecticides as DDT.

Other current WHO campaigns in the Western Hemisphere are aimed against yaws, smallpox, venereal diseases and yellow fever. In addition a number of projects are focusing on environmental sanitation, tuberculosis control, maternal and child health and nutrition.

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In mass campaigns against yaws, governments of 28 countries in various parts of the world, with the help of WHO and the United Nations Children's Fund, have examined 40 million people since 1948 and have treated 10 million with penicillin. This disease, which begins in childhood, destroys the skin and bones and often affects the face, body, legs, and arms.

The cost of examination for yaws is reported by WHO as 10 to 20 cents per person, and the cost of treatment as 30 to 80 cents. Some governments have organized their campaigns so effectively, according to a WHO report, that each field team of 6 to 10 workers can examine as many as 25,000 persons a month.

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In preparation for a technical discussion of educational requirements for entering nursing schools, scheduled for the Ninth World Health Assembly, to be held June 1956, nursing associations in all member countries of the World Health Organization are surveying nursing resources.

School Health

A group of Pennsylvania schools that used a visual-reminder device to keep track of progress toward getting medical correction of children's defects showed a one-third higher correction rate than a control group that used ordinary followup methods, according to the report of a study published recently by the Health Education Foundation. Financed by the Foundation, the study was made by the Social Science Research Center of Pennsylvania State University.

When a routine spring health examination of about 1,700 third- and fifth-graders in 20 schools had revealed defects requiring medical attention in more than 450 children, school nurses followed up each case, telephoning and visiting parents to persuade them to take their children to a physician.

In 15 of the schools the nurses kept track of the results with the help of an individual record card for each child, on which colored tabs showed at a glance what defects needed medical attention, what contacts the nurse had made, and whether or not the parents had taken the child to a doctor. Nurses in the 5 control schools made the usual efforts to get parents to act, but did not use the visual reminder.

Three months later, in the 15 schools that had used the reminder card the correction rate was found to be 60.7 percent; in the 5 control schools, 45.6 percent.

Similar results were not obtained, however, with dental defects. The schools that used the visual device to check progress in correcting dental defects obtained no better results than the schools in the control group.

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Juvenile Delinquency

After collecting information relating to juvenile delinquency from a number of Indian reservations the Subcommittee to Investigate Juvenile Delinquency, of the Senate Committee on the Judiciary, recently recommended steps toward prevention. These were:

That community-organization workers be employed on the reservations.

That in cases of illegitimate birth, law-enforcement officers should work to establish the child's paternity and to obtain support for him.

That child-welfare services be enlarged and improved with the help of special Federal appropriations.

That public-health measures be greatly extended.

That the States assume responsibility for the mentally ill, and that the Bureau of Indian Affairs enter into agreement with States to this end as rapidly as possible.

That a program of scholarships be developed for Indian youth, similar to the educational provisions under GI benefits.

That special vocational and technical courses be instituted in both public and Indian schools, for both adults and youth living on Indian reservations.

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After conferring with a committee of the National Council of Juvenile Court Judges, the U. S. Department of Defense recently liberalized its policy on permitting persons with juvenile-court records to enlist in the Armed Forces. Instead of requiring an applicant to wait 6 months after his probation has been completed before accepting his application for enlistment, the Department now passes on his fitness for the armed services at the time of his application for enlistment. If the applicant is not under civil restraint, if his overall rehabilitation appears to be satisfactory, and if he is otherwise qualified for service, he is permitted to enlist.

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As a step toward meeting the serious need for trained personnel to work with juvenile delinquents and adult offenders, the Rosenberg Foundation of San Francisco is contributing $20,000 toward the support of a 6-week summer course at the University of California, Berkeley, in 1956, designed to provide social-work teachers with an educational experience focused on the correctional field. The course will be offered jointly by the University's School of Social Welfare and the Children's Bureau.

Twenty-five social-work teachers and potential social-work teachers are being selected to be students of this course by a committee representing the University of California's School of Social Welfare, the Children's Bureau, the National Probation and Parole Association, and the Council on Social Work Education, from nominations made by deans of schools of social work or executives of correctional agencies.

The course will focus on sociological and historical analysis of the correctional field, adaptation of social-work treatment methods to correctional practice, and educational problems in social-work training of correctional personnel. All students will receive field-work placements in correctional agencies and will have opportunities to meet leaders in the correctional field in informal group discussions.

Students of the course will receive reimbursement for expenses incurred by their attendance.

Child Guidance

Financed by several foundations, a 2-year survey of the Bureau of Child Guidance of the New York City Board of Education has been conducted under the auspices of the Board by an advisory committee representing four disciplines—psychiatry, psychology, social work, and education; the administration of the city schools; and community groups.

In an effort to find out how and where the Bureau, whose current ratio of workers to school children is 1 to 5,000, could render greatest service and whether changes would make its work more effective, the committee studied the services it provides, in the light of the budget and the size of the staff. Its recommendations are included in a recently issued report, "The Bureau of Child Guidance in New York City Schools." Among others, they include:

Expansion of social-work and psychological services, with psychiatric consultation to help teachers and principals with the increasing number of children needing help.

Expansion of the psychiatric service as a resource in caring for children with "severe, intractable, and emergency problems."

Creation of a clinic service to provide intensive treatment for selected children needing it.

Establishment of a research and development unit to collect and analyze service statistics and to provide technical aid in research.

Substantial expansion of staff.

Establishment of a broad program of inservice training for teachers, with emphasis on mental health.

Better liaison with other agencies and bureaus concerned with emotional and behavior disorders of children.

Adoption

One in five of New York City's dependent and neglected children now in foster care is adoptable, if the more than 4,000 children recently studied by a committee of the Welfare and Health Council of New York City are a representative sample of the 14,585 children in foster care in the city.

Fourteen voluntary social agencies furnished information to the Council about the 4,031 children studied—practically all of them public charges now living in boarding homes or institutions. The agencies reported that one-fifth, or 773, of these children would benefit from adoption in the opinion of caseworkers who were in close touch with them. According to these caseworkers adoption would not be a sound plan for the remaining four-fifths.

Noting that race and age often stand in the way of a child's adoption, the committee points out that more than half of the 773 children considered adoptable are over 7 years of age and 63 percent are children of minority backgrounds.

Among other factors keeping many of these children from adoption, according to the committee, are the city's lack of a comprehensive program of adoption resources and the legal complications connected with the surrender of a child.

In its report, "Children Deprived of Adoption," the committee urges establishment of a public adoption service and of more workable legal machinery and improvement of casework services.

Mental Problems

The National Institute of Mental Health and the National Institute of Neurological Diseases and Blindness, Department of Health, Education, and Welfare, have expanded their work in mental retardation as the result of appropriation by the 84th Congress of $750,000 for this work in the fiscal year ending June 30, 1956. The Institute of Neurological Diseases, which received $500,000, is concentrating on basic research on the causes and prevention of brain damage. The Institute of Mental Health is concerned with emotional, psychiatric, psychosomatic, psychological, and socioeconomic factors.

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With a $50,000 contribution from a Philadelphia pharmaceutical company the National Association for Mental Health plans to step up its efforts to mobilize citizen support against mental illness. Specially assigned staff, working in cooperation with the Association's 33 State member groups and 425 local affiliates, will concentrate on strengthening and expanding community services for mental health, establishing new State associations, and increasing the number of local affiliates.

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New York State's joint legislative committee on mental retardation, created by the 1955 legislature with an appropriation of $35,000, is investigating mental retardation in the State—its extent, and the social, educational, economic, mental, and physical problems.

Here and There

Children and youth received major attention from the 1,600 delegates attending the first convention held by the newly merged American Federation of Labor and Congress of Industrial Organizations. In resolutions adopted December 7, 1955, the organization urged strengthening programs of maternal and child-health services and special welfare services for children, including aid to crippled children. The resolutions also urged further research and education in child life to help parents understand better what makes for healthy, happy childhood, and improved procedures for spotting and aiding maladjusted children and to handle constructively those who get into trouble with the law.

The relation between social science and parent education is the subject of a 3-year research program recently begun under the joint sponsorship of the Russell Sage Foundation and the Child Study Association of America. New York University's department of sociology and anthropology is cooperating in the study.

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Because aspirin kills more than 50 children a year and makes many more ill, the Food and Drug Administration, U. S. Department of Health, Education, and Welfare, recently requested manufacturers to label aspirin packages with a warning, such as "Warning—Keep out of the reach of children."

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Twenty-five pediatric centers are cooperating with the Public Health Service and the National Tuberculosis Association in the first large-scale, controlled study using an antimicrobial drug as a prophylactic agent against tuberculosis.

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Misunderstandings about adoptions are explored by Dr. Martha M. Eliot, Chief of the Children's Bureau, in a series of five articles recently released by the Bureau in mimeographed form. Single copies are available from the Bureau without charge.

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"Rainbow Round the World," a story about the United Nations Children's Fund (UNICEF), by Elizabeth Yates, has won the 1955 Jane Addams Children's Book Award, given by the Women's International League for Peace and Freedom.

Facts and Figures

About 7 in 10 of the Nation's 20 million families with one or more children of their own under 18 in 1950 were married couples with the husband under 45 years of age; about 7 in 100 were broken families. These facts were revealed by special tabulations of a sample of the 1950 census returns for primary and secondary families, recently prepared by the Bureau of the Census, Department of Commerce.

Three-fourths of the married couples with the husband under 45 years of age had at least one child under 18 and about 1 in 5 had three or more. Of the families with a female head other than a widow, almost two-thirds included one or more children of their own and 1 in 6 had three or more.

Between the date of the 1950 census and April 1954, the number of husband-wife families rose by an estimated 5 percent; other families with male heads, by 13 percent, and families with female heads, 4 percent. During the same 4-year period the total number of children under age 18 in the United States increased by 14 percent—from close to 47 million to almost 54 million.

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Farm households in the United States have been decreasing in number at a rate of about 150,000 a year during the last 5 years, and nonfarm households have been increasing by about 1,000,000 a year during the same period. These estimates by the Bureau of the Census are based on results of annual surveys, the most recent of which was conducted in April 1955. In that month there were 47,800,000 households in the United States—an increase of 4,200,000, or about 850,000 a year, since a comparable survey in March 1950.

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Women 15 to 59 years old in the United States who had been married by 1950 had borne an average of slightly more than two children, according to a July 1955 report on the 1950 census published by the Bureau of the Census, Department of Commerce. Farm women had averaged 3 children; city women, 2. For rural women not living on farms the average was about halfway between the farm and the city averages.

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Last fall's enrollments in public and private schools and colleges in continental United States are estimated at 39,557,000 by the Commissioner of Education, Department of Health, Education, and Welfare. The increase over last year's enrollment in kindergarten through eighth grade is estimated as 1,300,000; in ninth through twelfth grades, 7,422,000; in colleges and universities, 2,740,000.

READERS' EXCHANGE

THORNHILL: Confirmation

The excellent article, "Unprotected Adoptions," by Margaret A. Thornhill (CHILDREN, September–October 1955) was of particular interest to me because the Senate Subcommittee to Investigate Juvenile Delinquency is currently making a study of interstate adoption practices. Public hearings were held on this subject in Chicago on July 15 and 16, 1955. In addition, a national survey has been conducted by this Subcommittee on interstate adoptions arranged by unauthorized individuals.

The facts thus far uncovered confirm the position taken by Miss Thornhill in her article—that the roots of the black market, and most of the abuses in the adoption field, can only be eradicated by the improvement of services to the unmarried mother, the adopting parents, and the child.

One of the cases brought to my attention during the investigation highlights the direct connection between inadequate adoption services and poor placements. A juvenile court in the South has been making large-scale placements since 1946 throughout the United States. The community in which the court is located is almost completely lacking in adoption services; therefore, the court has played the role of an adoption agency.

In one instance, a 6-year-old boy who had lost his mother was sent to California for adoption. There had been no investigation by the court of the adoptive home. It developed that the prospective adoptive couple wanted this child to replace their 6-year-old son who had recently died. They quickly became dissatisfied with the second little boy and he was transferred to another couple who thought they wanted a child. This second family changed its mind after 2 years, and transferred the little boy to a third family. By this time, the youngster was so maladjusted that he was difficult to control. He eventually tried to kill his third foster mother by putting a poison substance into her coffee. At present, he is in an institution.

This case illustrates the need for a preplacement study of the child and adoptive home, particularly in instances of interstate adoptions.

Our preliminary findings showed that:

1. The greatest abuses involving the interstate and intrastate placements of children for adoption occur in areas where there is a gap in child-welfare services.

2. Unmarried mothers are often compelled by the lack of services to use facilities of the black market.

3. There is a substantial amount of commercialized placement of children across State lines that warrants serious consideration of Federal legislation to eliminate this practice.

The greatest need, however, is an accurate and systematic assembling of facts relating to interstate placements. It is difficult to remedy a situation until all the facts are assembled. Once there is a dissemination of facts about a troublesome situation, the community, on its own initiative, can often rectify the problem. In Chicago, the subcommittee's investigation brought to the attention of public officials certain dangerous adoption practices in their courts. As soon as these practices were brought to light, they were immediately corrected by court officials.

Although some regulatory legislation may be necessary to strike at the baby racketeer who is operating across State lines, I feel that the greatest service the subcommittee's investigation can render to the community is the highlighting of the facts in the interstate adoption picture. Once this is done, I feel confident that the need for improved services on a local scale will be firmly established, and that the improvements will come on a local level without the need for extensive State or Federal legislation.

Estes Kefauver
United States Senator

ALBEE: A different focus

I am particularly interested in "Group Work With Hospitalized Children," by Constance Impallaria Albee (CHILDREN, November–December 1955), since my work is with both outpatients and bed patients in a pediatric hospital where I have been given the opportunity to institute a program with somewhat similar aims.

However, we have planned our program with a different focus. We have offered the help to hospitalized children on a prescription basis so that the child does not have a choice as to whether or not he enters the program but is, so to speak, ordered into the program. Our experience has been that the child quickly adjusts to the environment and we have had only one child in the 18 months' experience who has been even moderately resistant. Our goals, although in some areas confluent with those described in Mrs. Albee's article, vary in others. There are three focuses: prophylactic for children facing long-term hospitalization; diagnostic, for those children who enter the hospital with difficulty or perhaps who have already acquired problems within the hospital setting; and therapeutic, for those children who remain for a prolonged period.

Many children in pediatric hospitals remain for months, even years, because of orthopedic, cardiac, and other chronic problems. We find that the peer group gives the child an opportunity to exhibit his behavior in relation to his peers as well as to the adult, and, as has been pointed out by others, affords an excellent diagnostic opportunity. The same situation may be utilized in ongoing therapy.

Our program concentrates on the individual within the therapy groups. To be sure there is often a wide overlapping. It is evident from our work, as well as from Mrs. Albee's, that the education of the groupworker in addition to his routine groupwork training must encompass understanding of the individual. The groupworker should understand the psychodynamics of children well enough to pick up deviations and evidences of disturbance. This is valuable to the worker in designing the program so that the individual child may benefit from it therapeutically.

We have been conducting groups of the type described for about a year and a half and are persuaded that they should be continued. It is important to have a careful social study of the family beforehand or as the child is brought into the group; moreover, it becomes increasingly evident that a followup, especially for those children who come from poor cultural and poor economic backgrounds, such as those on clinic service, should be available through a family-centered project.

Henry H. Fineberg, M. D.
Director, Child Guidance Clinic
Children's Memorial Hospital
Chicago

BECK: The place of values

I have deep conviction of the importance of continued emphasis and reemphasis on the crucial part which cultural values play in the etiology and treatment of delinquency, as well as other forms of child maladjustment problems. To round out Mr. Beck's observation ("The Exiled Delinquent," by Bertram Beck, CHILDREN, November-December 1955) not only is the stress on "aggressive, individualistic competition in conflict with the ethical and social values which we teach children," but delinquency may very well be an unavoidable byproduct of an individualistic social organization.

Dean Kirchwey, who taught courses on criminology at the New York School of Social Work for many years, often spoke of delinquency as the price which a pioneer society paid for its enterprise and material progress. Similarly today we can see delinquency as the price exacted by rapid social change or "progress."

What I believe to be important is that, having recognized the interconnection between cultural and social factors in individual maladjustment, we do not content ourselves with merely improving the procedures which courts, institutions, and other correctional and treatment agencies employ, important though these may be. At the same time, we must do what we can to make sure that human values receive full consideration in all planning which influences the lives of people.

Lewis Mumford has for many years called attention to the importance of social considerations in city planning and construction. At the moment a commission is actively involved in planning improved transportation facilities for the New York metropolitan area, an area which holds one-tenth of the population of the Nation. It would be interesting to know how far factors bearing on healthful family life, constructive relationships between parents and children, rich neighborhood life, closeness to the soil, are given weight in this commission's planning. I think it is fair to say that up to now much of our community planning has moved from partial and fragmented functional bases rather than from integrated social patterns in which human values are accorded the place they deserve.

Professional workers engaged in the field of social relations, including social workers, must get together and spell out as clearly as possible some of the essential values in family and child life which must be conserved and strengthened, and then persistently knock at the doors of all the individuals and groups who, in different ways, shape the pattern of our common life.

Herschel Alt
Executive Director
Jewish Board of Guardians
New York City

VAUGHAN: As New York does it

At the Bureau of Child Guidance, which is part of the New York City school system, we have seen similar anxieties aroused in school personnel by clinical staff to those cited by Dr. Vaughan in his valuable description of Massachusetts efforts toward a total mental-health program. ("Mental Health for School Children," by Dr. Warren T. Vaughan, Jr., CHILDREN, November-December 1955.) To orient new staff, we explore with them not only the probable anxieties of teachers, but also their own as they face again the authoritative figures of their childhood.

With us, also, the school refers its most difficult cases first. Only if teachers get diagnostic and treatment service for these, can they see value in using consultation for less disturbed children.

Dr. Vaughan states that in Massachusetts teatment is carried on in mental-health centers, because "psychiatric treatment functions cannot be properly carried out in school settings." In general, we would agree. However, in our school system of nearly a million children, we have found it helpful to place all the mental-health functions in the school system.

We have Bureau centers which are part of the school system, but not administratively attached to a school. From these centers workers fan out to their assigned schools. As they become integrated into the school and its community, school psychologists and school psychiatric social workers work increasingly with parents and children right in the school, going back to the centers for psychiatric consultation, and bringing into the centers cases for psychiatric diagnosis and treatment. It is true that under such a system skill and patience are required to separate the clinical functions from those of the dean's or the guidance counselor's office; but it can be done if each professional discipline has competence in and conviction about its role.

Rose Goldman
Chief School Psychiatric Social Worker, Bureau of Child Guidance, Board of Education, City of New York

PERIODICALS: A common oversight

It seems most unfortunate that many social workers seem sometimes to resent the role of the juvenile-court judge, and likewise, perhaps, some juvenile-court judges resent the role of the social worker.

Undoubtedly some of the misunderstanding may come from the fact that judges of family courts operate under strict rules of law which they must construe and administer as they find them. Social workers, on the other hand, as members of social-welfare organizations, operate under "policies," which can be easily changed or revamped to meet different situations.

Many members of these groups do not understand the limitations or characteristics of these respective fields. Yet there is now a growing feeling that the existence of juvenile courts is necessary to protect the constitutional rights of children and their parents and at the same time the services of professional social workers, on the other hand, are generally respected and made use of by the better type of family-court judges. However, in many modern periodicals covering the work of social agencies and welfare of children, the work of juvenile courts, and the thinking of juvenile-court judges, are too often entirely overlooked or neglected, when they might make a valuable contribution out of their wealth of experience.

Why not give juvenile-court judges a little more opportunity to be heard, and to help plan needed facilities in the field of child welfare and rehabilitation of problem youth?

Walter H. Beckham
Judge, Juvenile and Domestic Relations Court, Miami, Fla.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

PRENATAL HEALTH EXAMINATION LEGISLATION; analysis and compilation of State laws. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. 369. 1954. 55 pp. 25 cents.

This publication reproduces the sections of the State and Territorial laws requiring prenatal blood tests for syphilis.

SURVEY OF YOUTH FACILITIES AND PROGRAMS IN CERTAIN LOW RENT HOUSING PROJECTS OF THE PUBLIC HOUSING ADMINISTRATION (BY FIELD OFFICE). Housing and Home Finance Agency, Public Housing Administration, Office of Special Assistant to the Commissioner (Racial Relations). 1955. 79 pp. Single copies from the Public Housing Administration without charge.

Recreation services and facilities for children 6 to 18 years old in 51 housing projects to which people of racial minorities have access are described in this survey. Some of the projects are completely segregated; others have some form of integration in occupancy and activities. For each project the report specifies types of programs offered; social agencies that have helped with them; benefits to the children, the project, and the community; and what needs to be done. The projects are located in 26 cities in 22 States.

EMPLOYMENT CERTIFICATES—HELP YOU HELP YOUTH. Department of Labor, Bureau of Labor Standards. Bulletin 183. 1955. 23 pp. Single copies from the Bureau of Standards without charge.

Addressed to all who have any part in issuing employment and age certificates, this bulletin discusses the relation between certificates and enforcement of school-attendance and child-labor laws, explains procedures generally found effective in making certificates serve their intended purpose, and describes the kinds of services given applicants in some issuing offices which might be available to all young people who need them. It also presents a guide for issuing certificates under the child-labor provisions of the Fair Labor Standards Act.

ILLNESS AND MORTALITY AMONG INFANTS DURING THE FIRST YEAR OF LIFE. Selwyn D. Collins, Katharine S. Trantham, and Josephine L. Lehmann. Department of Health, Education, and Welfare, Public Health Service. Public Health Monograph No. 31. PHS Pub. No. 449. 20 pp. 15 cents.

Data obtained through household canvasses are supplemented in this report by information from official records showing trends of total infant mortality in the birth-registration States for 1915–53; trends for 1927–51 by sex, age, and geographic section; and mortality for 1950 by sex, age, and cause.

ACQUIRING SURPLUS PROPERTY FOR HEALTH OR EDUCATIONAL USE. Office of Field Administration, Department of Health, Education, and Welfare. 1955. 15 pp. Single copies available from the Office without charge.

This guide explains how eligible groups can acquire Federal surplus real or personal property for health or educational use, under the Federal Property and Administrative Services Act. It lists the addresses and telephone numbers of the seven regional property coordinators and also of the State directors of surplus property.

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Page 19, Westchester County (N. Y.) Department of Health.

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What Houseparents Should Know

A Program for Child Amputees

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◀

Belonging to each other but to no community, this mother and child are part of the great human stream of migrant farmworkers and their families that flows through Colorado's sugar beet fields, on the way from Texas to Iowa each year. Many such streams of families in continuous mobility in every region of the country are an important part of this country's agricultural economy, but the children in them have little opportunity to experience normal family and community life. Aware of their need for health protection, a number of States, including Colorado (see page 43), have been taking steps to bring them health services.

374161—56

◀ *the authors*

A pediatrician, with 12 years of private practice, mainly in rural areas, Dr. Ruth B. Howard has been in the Colorado health department in her present capacity since the end of World War II, except for 3 years on leave. One of these she spent at Johns Hopkins University securing a public-health degree and the other two in the Middle East in charge of maternal and child health for the United Nations Relief and Works Agency for Palestine refugees.

Gisela Konopka's early work with progressive schools and children's institutions in her native Germany was interrupted by the Nazis' rise to power and her own incarceration in a concentration camp. After release in 1937 she went first to Austria, then to France, and eventually arrived in the United States in 1941. Since then she has studied social work at the University of Pittsburgh, practiced therapeutic groupwork in a child-guidance clinic, and published two books and a number of articles. She has been on the faculty of the University of Minnesota since 1947.

Just two issues back Pauline Stitt (above) wrote in this journal about the importance of interagency communication. (CHILDREN, November–December 1955.) With as strong a belief in nutrition services to crippled children she herein collaborates with a nutritionist who has done considerable research on prenatal nutrition as well as on nutrition in children. The latter investigations Bertha S. Burke (below) has been carrying on for the past 20 years in connection with the longitudinal study of growth and health at Harvard. Before engaging in the maternal and child health and crippled children's aspects of public health, in both State and Federal positions, Dr. Stitt practiced medicine privately as a pediatrician.

With a medical degree from the University of Michigan, Charles H. Frantz has been practicing orthopedics privately and in a crippled children's clinic for the past 20 years. A member of the American Academy of Orthopaedic Surgeons, he is one of two directors of the amputee clinic at the Mary Free Bed Children's Hospital, Grand Rapids.

A psychologist who has specialized in child development and guidance, Ethel Kawin has long been interested in parent education. In the past she has served as a consultant for the 5-year expanded parent-education program of the National Congress of Parents and Teachers and has also established a training course for lay leaders sponsored by the Illinois Congress of Parents and Teachers and the University of Chicago. She has also been on the staff of the Illinois Institute for Juvenile Research.

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How teamwork between the State and local communities is striving for . . .

BETTER HEALTH FOR COLORADO'S MIGRANT CHILDREN

RUTH BORING HOWARD, M. D.
Chief, Maternal and Child Health and Crippled Children Section
Colorado State Department of Public Health, Denver

IN THE SPRING OF 1955, a truck carrying 52 people overturned on a highway in eastern Colorado. One infant was killed and several passengers were injured. The passengers who were not hospitalized pressed on to Wyoming to the work in the beet fields for which they had been recruited in Texas. Since to these agricultural workers the loss of a few days' work at the height of the season might make the difference between one or more meals a day the next winter. For those who could not go on, the sugar company provided medical care and housing, clothing, and a funeral for the dead infant. Nevertheless, some long drawn out problems remained for three families who, when hospitalization was no longer required, were lodged at the labor camp in Fort Lupton, Colo.

One man who had suffered a head and nerve injury in the accident came to the camp clinic because of headaches, and because he could not use his right hand well. He was unable to work, and while the sugar company furnished groceries, the family's only money came from what one child could earn picking beans. Yet, although this man was obviously worried about his injury and willing to cooperate in what he understood, he failed to return as recommended to the hospital 25 miles away for checkup and treatment to prevent a permanent handicap.

At this point the clinic called in a medical social worker. She found that nobody in the family spoke English and that the father did not know how to get to the hospital and had no means of transportation. The trucker who had persuaded him to come north to work for the first time, and on whom he depended for most arrangements with the Anglo world, had gone off to another State.

The medical social worker secured appointments at the hospital for the injured man and arranged for the hospital social worker to guide him. He was accompanied to the hospital for his first visit, shown how to use public transportation to return for his treatment, and given lodging near the hospital when he needed it. Interpreting the personal and medical needs of this man and his family to the sugar company and interested agencies, the medical social worker also helped work out a plan for their rehabilitation.

The Health Program

Helping this family to become self-sufficient again was a small but definite triumph, made possible because of a health program for agricultural migrant workers which had just got underway in two counties in Colorado. In July 1954 a project was agreed upon between the Children's Bureau, Department of Health, Education, and Welfare, and the Colorado State Department of Public Health for improving the quality and availability of health services to mothers and children of migrant agricultural workers who come into Colorado. This involved setting up a minimal State structure for coordinating various local plans and then proceeding community by community to organize plans which would fit the needs and facilities of individual localities. At every step consideration was given to improvement of communications: between the migrant workers and local residents; the agencies and the individuals concerned; the local communities within the State; and the States through which these migrants traveled.

The two largest camps in Colorado were originally built by the Federal Government under its wartime farm labor program and provided with clinical facilities. When the camps were later taken over by the local growers, the clinical facilities were no longer staffed except during the summer of 1949 in Fort Lupton.

In the spring of 1954 the Federal Public Health Service and the State and local health departments cooperated in a program of screening migrant families passing through Fort Lupton on their way to other areas to work. Emphasis was particularly placed on tuberculosis and venereal disease. The program was extended through the growing season to long-term residents of the camp. However, they were confused by its limitations when they had health problems other than those looked for in the screening service.

Preparation

The new project got underway during the winter of 1954–55 under the direction of the chief of the maternal and child health and crippled children section of the Colorado State Department of Public Health. In addition to a special grant for its support, the Children's Bureau furnished consultation and assistance with interstate referrals through the Bureau's regional staff. An experienced medical social worker, who was thoroughly familiar with the resources of the State, was assigned by the State health department to work full time with the project. She assisted in community organization and project planning, serving as a liaison with other State and Federal agencies, as well as with those on the local scene—promoting interagency cooperation by keeping them better informed.

Both MCH director and medical social worker made exploratory visits to a number of Colorado communities to gather information about health and welfare resources already available, housing facilities, methods of labor recruitment, numbers of workers and families concerned in specific areas, and dates of peak activities. They contacted a wide variety of persons since reports of community attitudes varied considerably with the personal feelings of the individual, as well as with the philosophy of the community regarding health services and migrant laborers in general. This meant proceeding slowly, but proved to be time well spent since it helped the local people to understand that the Department was interested in planning with them and not in trying to impose a program upon them and that each feature of any program set up in the community would be mutually agreed upon by the State and the locality.

Migrants and Communities

Migrants represent diverse population groups. Some of those who come to western Colorado for the peach-picking season are relatively well adjusted socially and economically, and are able to make their own arrangements about medical and health matters if local conditions are not too bad. Others spring from a poor social and economic background within the Anglo culture and include many unstable marginal workers. In Colorado the majority of agricultural migrants have a Spanish-speaking or American Indian cultural background. The Spanish-speaking groups are by no means homogeneous, as they include descendants of early Colonial Spanish, first- or second-generation "Texas Mexicans," and some Mexicans who are not yet naturalized as citizens. The Indians come from the northern plains tribes and from the arid Navaho reservations of the Southwest.

Migrant labor is an essential factor in the growing and processing of various fruit and vegetable crops, on which the economy of some important rural areas is based. Resident labor would be used entirely if enough were available at the short peak seasons of need, for though the migrants are an asset at the times when work is plentiful, they may become dependent on the community in slack seasons. This colors the attitude of the community toward them, creating a tendency to regard them as aliens.

Local communities and groups within communities differ widely in their interest in improving the health of migrants. Some offer far better health facilities than others, but generally there has been no consistent attempt to help these people utilize available facilities to full advantage nor to teach them health principles on which to plan and conduct their lives. Acute medical problems are cared for, particularly those of an emergency nature and those which interfere directly with work potential, but many chronic problems go untended and living conditions are far poorer and less hygienic than they should be.

Growers and processors often assume some responsibility where doing so directly affects the migrants' work potential or future recruiting. Welfare agencies often spend considerable energy in sending dependent people back to their place of residence, if that can be determined. Individuals and local groups give some direct assistance. But the majority of the families, who when working could pay something toward their medical care and who need to be guided in what is important for their health, find little of the type of assistance they need.

Two Projects

As a start in improving this situation, two local projects were set up for the 1955 growing season, based in the largest labor camps in the State. The Fort Lupton camp, in Weld County, houses a maximum of about 2,000 workers and their families, all Spanish-speaking persons from Texas and New Mexico, except for a few Indians. They come to do stoop labor in the sugar-beet fields, in small vegetables for the canneries, and in the potato harvest. The work is spread over about 4 months, although there is much seasonal variation.

The camp at Palisade, in Mesa County, can house about 1,000 persons. While the peak season lasts only about 2 weeks during the peach harvest, the camp is used from early summer for those who come to work on other fruit and small vegetables for the canneries. Many are residents of Colorado, especially the 20 percent who speak Spanish. The remainder, who drift in from almost any State in the Union, is predominantly of Anglo background, and ranges from teachers and students on vacation to unstable wanderers. There are a few Negroes.

Two extra nurses were added to each of the two local health units to work in the camps. In Fort Lupton a secretary was also supplied and local physicians served in rotation in the clinic. Provision was made for travel, supplies, maintenance of clinic facilities, and payment of fees to physicians serving in the clinics at Fort Lupton. After discussion with the local professional groups, it was decided not to make provision for dental services, for hospital services, nor for fees for service in physicians' offices. The question of payment for diagnostic laboratory services and X-ray services was left open. Hospitalization, private medical fees, and essential transportation of patients were arranged for by the community when the migrants could not provide their own.

In the Fort Lupton camp, the clinic staff consisted of a public-health nurse, a Spanish-speaking graduate clinic nurse, and a Spanish-speaking secretary. Medical clinics were held six nights a week. Some medications were supplied directly, some on prescription. A mobile X-ray unit was installed and chest plates were taken of all who could be interested in having them, although there was no attempt at mass screening. Patients were asked to pay whatever they could, up to $2, for a call at the medical clinic, but no one unable to pay was refused.

In Mesa County, a registered nurse assigned to the camp and a public-health nurse working in the camp and in the surrounding area offered first-aid and nursing service and assisted patients in securing medical care through referral to local physicians. They also provided health supervision for the day-care center set up by the workers of the National Council of Churches. A physician from the town of Palisade was on call for advice.

It was the responsibility of the nurses in both camps to induce as many of the migrants as possible to seek preventive health services such as immunizations, chest X-rays, and laboratory tests, whether in the camp clinic or in a physician's office, and to steer the children and expectant mothers into well-child conferences and prenatal services.

Use of Services

Clinic services were used at some time by 22 percent of the migrants at Fort Lupton, and 17 percent of those at Palisade. In both camps the medical conditions most frequently seen were diarrhea and upper respiratory infections.

There were 35 known pregnancies in Fort Lupton, 23 in Palisade. All who delivered during their stay in the area did so in hospitals, except one woman who was delivered in the Fort Lupton camp by a midwife because of lack of transportation. One infant died of bronchopneumonia in Fort Lupton camp. This child when seen the night before in clinic had had very slight symptoms of illness.

In Mesa County the welfare department assigned responsibility for work in the camp to one worker, who was freely available for consultation at all times with the nurses. Often they could make plans together for solving the family's immediate problems without recourse to public assistance. As a result only eight cases were referred to the welfare department for assistance during the summer, a considerable drop from the record of previous years. The medical social consultant for the statewide project gave technical consultation to the staff of both camps and some direct service to patients referred with chronic illness or with other problems.

Migrant mothers and children on their way to the camp clinic. Mothers who have received medical attention for a sick child or first aid from the camp nurse are the most apt to take advantage of the preventive services of the clinic.

During a preseason orientation period a social anthropologist instructed the camp nurses in the social and cultural aspects of the migrants' health problems. At this time the nurses were also informed that being a part of available clinical and nursing services was only a beginning of their responsibility. They were to follow up contacts and to seize every opportunity for giving a little advice or guidance or for attracting groups for informal health education. When care or advice was rejected they were to try to discover the reasons, and to keep a careful record of their experiences.

During this period the health educator of the Colorado State Department of Public Health helped the nurses prepare materials for health teaching among the migrants. In actual practice camp residents come in from work late and go to bed early. Thus, while in both camps the nurses subsequently gave talks and showed films to recreation and study groups assembled by the workers of the National Council of Churches, these were only moderately successful. The most effective teaching was done through their individual contacts in which they gave considerable instruction to mothers on infant and child care.

Our experience indicates that migrant workers will often accept health services when these are offered in terms they can understand, and that in general their medical problems are like those anticipated in the resident population but aggravated by the precarious circumstances of their lives.

The migrants' pattern of living discourages planning for the future and thus probably contributes to their failure generally to show interest in preventive health services in any degree comparable to their interest in medical care. They are not indifferent to the welfare of their children, but taking an apparently well child to a clinic gives way in order of importance to other concerns, such as making enough money for next winter's food. However, many can be led to make better use of available health facilities through contact with someone they trust who has sympathetic understanding of their problems and is able to help them plan a reasonable solution that they can carry out.

Some Case Stories

In this past summer's experience the nurses' efforts to lead the camp residents toward good use of medical and health resources ran the gamut from success to failure.

One couple in their teens came to the clinic for prenatal advice because a woman they had become acquainted with in the camp was attending the maternity clinic. The nurse helped them make plans for a hospital delivery, and persuaded the girl to nurse her baby if she could, which she had not intended to do. This proved fortunate, for the baby was born prematurely. On a home visit immediately after the mother's return from hospital, the nurse found the baby and a large doll, each wrapped in a blanket, lying side by side on the bed. She showed the young mother in this and subsequent visits how to keep the baby screened from flies and away from close contacts and explained the importance of her own diet to the baby's health. Though this was the season of diarrhea, the baby remained well and gained. The grateful young parents proudly brought their child regularly to the clinic for checkups.

In another family the 9-month-old twins had three bouts of severe diarrhea, necessitating two periods of hospitalization. They were very sick children. Their mother was clean, conscientious, and much interested in her children's welfare, but she was living in a shack on a farm outside the camp and no home nursing visits were made to her. This indicates a flaw in the services, for she might have been taught, by demonstration in her own home, how to protect her babies better, and particularly how to feed them. Presumably she learned in the clinic, however, for at the end of the summer the children were doing better; by then she had improved their diet and modified the malnutrition which had complicated the picture.

A 2-year-old child was brought by his mother to the clinic because he had been sick for 2 months. He looked malnourished and chronically ill and showed a fever and swollen glands. The physician, suspecting tuberculosis, recommended diagnostic laboratory work, but prescribed no medication pending blood and X-ray reports. The mother was told that the blood tests and chest X-ray would have to be done at the Weld County Hospital the next day, and that the child should then be brought back to the clinic for treatment. The parents did not take the child to the hospital for the tests. Three days later in the course of a home visit the nurse was told that the family would be leaving the camp in a day or two because of lack of work and had not gone to the hospital because they had no money. Possibly more might have been done for this child if some sort of treatment had been started when he was first seen, or if laboratory work and satisfactory X-ray equipment for young children had been available in the clinic, instead of 25 miles away.

One of the most interesting experiments for migrants in Colorado during the past summer was in the educational field. The school district in Wiggins, in Morgan County, adjacent to Weld County, set up a summer school for migrant children from the end of May to the first week in July, assisted by funds from the Colorado State Department of Education. The children were brought to the Fort Lupton clinic for physical examination and X-ray. While the plan had been to give no injections so that this health experience would be remembered as free from pain, the clinician found five children with inflamed throats and elevated temperatures and ordered penicillin for them. However, a local church group had supplied ice cream and cookies which were served at the end of the clinic, so that the children left smiling. The county public-health nurse gave the subsequent injections to the children needing them, and with the medical social consultant followed up with home visits to the families of the few children who had specific medical problems.

The school program itself contributed to the children's health. It emphasized hygiene instruction by having the children take shower baths, brush their teeth, and wash their hands. A bountiful and well-cooked hot lunch was served every day, including a large proportion of protein foods and milk. Through the help of the local PTA, this was available to all the children, whether they could pay the fee of 20 cents or not. Doubts about the acceptance by Spanish-speaking children of Anglo food were resolved by the way these youngsters attacked the lunch, and particularly the way they all drank milk. Figures for weights and heights which were recorded at the beginning and end of the school term show that the children during this period gained as much in both height and weight as would be expected during a period of 6 months for Anglo children in Colorado of the same ages and on an adequate diet.

Evaluation and Plans

In the beginning of the program the many groups in the two counties touching the lives of migrants knew little of each other's purposes and resources. Complete understanding can hardly be expected to be accomplished in one season but the progress has been encouraging. From the very first, representatives of the county welfare department, the local employers' groups, the State employment service, the Mission to Migrants of the National Council of Churches of Christ in America, and the Girl Scouts of the U. S. A., as well as of the local health departments and the local medical societies, were brought into the planning. In Mesa County an advisory committee on migrants representing these groups was formed which will continue to function in the coming season.

At the end of the season meetings were held in both Mesa and Weld Counties to discuss the summer's experience, to attempt to evaluate the strengths and weaknesses, and to plan for another season. In both areas the programs were considered definitely successful. The consensus was that the health needs of the people in the camps had been handled earlier and more smoothly than had been the case in the past, and complications had thereby been reduced. Members of the medical profession in both areas were pleased at being relieved of some unnecessary and minor work. They used the help of the public-health nurse more effectively as they became familiar with it.

Relationships and communications between local agencies had clearly improved as these agencies learned more about each other's functions and resources. In Mesa County, where the nursing staff had worked closely with the representatives of the peach growers and had made contacts in the community, an excellent relationship had been established which was reflected in better understanding of the local health department.

Both communities have expressed the wish to have a similar program next year and have suggested few changes. They do not seem as much concerned as the staff members of the State health department over certain definite shortcomings in last summer's program. While it was obviously essential to begin at the focal point of local interest, the camps, these programs did not serve the migrants throughout their respective counties nor even throughout the major part of the counties. Few of the migrants living in the small camps elsewhere in the counties or on the ranches sought them or even knew about them. Next year there will be a campaign of publicity to inform the employers, ranchers, and other interested groups throughout the county earlier and more completely as to the services they can expect for their employees. The public-health nurses will cover a wider area and a social worker may be attached to each project for the summer season.

One of the first steps in setting up the last summer's program was to design record forms, with the assistance of expert consultants from the Children's Bureau and the Public Health Service. This proved to be an exacting task, since it was essential that the records be readily usable by the local personnel in various situations and still serve as effective channels for the transfer of information to other agencies within and without the State. These forms proved useful in operation, but some important changes must be made if they are to form the basis of a widely used record system. More thought must be given, particularly to the means of transferring brief essential information about a patient or a family from one area to another, either with the family or speedily upon request.

The summer's experience has nevertheless confirmed our faith in the principles on which the local projects for migrants were set up. Other areas in the State are now expressing an interest in making some health plan for migrants for the coming season. In working with them we shall be even more acutely aware that to perpetuate itself a local program must be so oriented that it can eventually become part of the health services available to all residents of the community throughout the year. Hence, it must take into account the economic facts of life; it must enlist wide local interest, understanding, and support; it must recognize the cultural attitudes both of the migrants and of the community and must make definite efforts to resolve the differences between them; and, because the flow of migrant labor is governed by the variations of growing seasons, it must always be flexible.

To further strengthen the program, we have been working this winter on efforts to improve communications with everyone concerned with the health of migrants—in all levels of agencies and in communities both in Colorado and at the migrants' points of origin and destination. We have also been trying to consult with as many interested groups as possible on methods of improving the record forms, with particular emphasis on their use in referring patients from one service to another. Eager to cooperate in any moves toward regional planning, we are continuing to advocate the formation in Colorado of a State committee on migrants, concerned with transportation, employment, working conditions, education, health, housing, and other social problems. With such a committee and with the State structure properly integrated with a regional structure, we believe that health services in local areas can be so developed and fitted together that migrants and local families alike can receive the care they need.

"Science is needed in solving problems of human subsistence: when two-thirds of the world is poorly fed and part of the remainder is overfed, we need to put science and ethics to work. When we profess the brotherhood of man and cannot act the part and do not know why, we should at least make the attempt to put science to work in studying human relations."

E. C. Stakman, "Science and Human Affairs," in Science, *February 9, 1951.*

Should houseparents be told ab
of the children in their care
says this article in discussing . . .

WHAT HOUSEPARENTS SHOULD KNOW

GISELA KONOPKA, M. S. W.
Associate Professor of Social Work, School of Social Work, University of Minnesota

I RECENTLY VISITED a large institution for delinquent boys. One of the supervisors asked me what I considered the most important subject to teach houseparents. I finally came up with two words which sound simple and yet demand so much. They are "understanding" and "respect." These words comprise a wholehearted conviction that even the most difficult child is to be met not only with a sense of duty or even of pity but with a deep respect for the capacities and the possibilities that lie dormant in him.

This conviction is not always easy to attain when one is confronted with a solemn, suspicious boy or with a brash, showoff girl, or with repeated disobedience in spite of kind admonishment. It is only human to become impatient and angry, and sometimes even to feel betrayed. Only a conscious effort at empathy can help us overcome those feelings. This means trying to understand so deeply that one can feel almost like the other person and to be able to add one's own strength to his weakness, despair, or hurt. It is a task that asks for the combination of all our capacity of observation, of knowledge of human behavior plus the humble awareness that mistakes can be made by everybody, ourselves included.

In Thornton Wilder's beautiful book, "The Bridge of San Luis Rey," the old abbess says to a woman who comes to her, torn by feelings of guilt: "All, all of us have failed. One wishes to be punished. One is willing to assume all kinds of penance, but do you know, my daughter, that in love I scarcely dare say it—but in love our very mistakes don't seem to be able to last long."

I sometimes wonder whether we always look at mistakes made by children with such love. And yet, it is only with this attitude that we will be able to understand and to work.

If we want to understand the problems of children in institutions we must realize that they are different for each child and that we cannot draw a picture that will fit everyone. If I make such an attempt in this paper, it is with full awareness that it can be only a generalized picture which must be filled in with the unique problems of each individual child.

Early Problems

Most of us find some difficulty in entering a new situation and meeting new people. How much more difficult must it be for a child to enter a new environment and new relationships, which he has not chosen, which are imposed upon him because of a previous disaster and which will surround him for an indefinite period of time.

Children come to our institutions because of difficulties in the family or because their homes have been broken either by illness and death or by strife. They also come because they themselves are full of emotional problems or because they have committed an act which is not acceptable by society. Whatever

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Adapted from a paper presented at the North Dakota Welfare Conference, October 1955 hem apart from the regular flow ung child and it takes them away from protection and happiness of a normal family.

It is not a fad that social work has placed such great emphasis on family placement so that today there are fewer and fewer institutions with children whose only reason for being there is that they are orphans. The increasing understanding of the child's need for security and happiness has brought this about. But this does not mean that institutions have not and will not have a very vital part to play for some children. The children we have in our institutions today—and this will be increasingly true in the future—are far more difficult to work with than those we had years ago. There are few sweet youngsters who are easy to handle. Such children are placed in foster families. The children in institutions today are those whose hurt has left bad scars and who, therefore, cannot accept a normal family life. Their fear, distrust, and resistance to institutional placement is nevertheless great. To many of them all adults are powerful giants whom they hate because of their brutality or unpredictability.

Two Children

There is, for instance, Joan who came to an institution because of the violent attacks her father made on her mother when he was drunk. In a fearful fit Joan had thrown herself against her father but was restrained and hit by her mother. How could Joan understand the complicated relationship between those two people? She could see no justice in the world and she felt justified in resisting adults wherever they were, in school, at home, or on the street. The only recognition and kindness she had experienced came from other youngsters in similar boats. Joan joined a gang and had sex relations at a tender age because this gave her a feeling of being somebody and brought her caresses instead of beatings.

At the point of entering the institution, Joan felt caught. She felt that the only happy association in her life had been taken away from her and was counted a crime. She expected brutality, inconsistence, and punitiveness from the adults in the institution. She expected fights with other children who would not understand her. She expected intolerable limitation of all her drives and interests, and she was set to fight whenever it occurred.

Then there is Jim, the little 9-year-old who came from a well-to-do home with a father who worked hard on a professional job and went to night school in addition and with a mother who was active in the community and took conscientious care of her three children. Jim's two older sisters came along beautifully in this environment, but Jim, the last born and the only son, over whose birth the parents were so happy, seemed to destroy their hopes for him. He was slow, had difficulties in learning and withdrew into himself. His father became impatient with him and his mother tried to teach him, so that Jim's life was a constant nightmare of feeling that he disappointed his parents. He experienced fits of jealousy of his beautiful and intelligent sisters and deep guilt over having such mean thoughts. To Jim adults and "smart kids" were all-powerful while he was an insignificant and incapable little human being. Because he did not dare to attack others he withdrew into himself and began a fantasy life that frightened his family. Eventually he was sent to a treatment institution.

Entering the institution represented for Jim his final failure. This was realistic because his family had given up hope of helping him. It added to his sense of guilt and made him feel that here was a punishment which would also fail to help. He expected exasperation on the part of adults and teasing on the part of other children. He had a deep fear of having lost his family altogether.

These two very different children illustrate the wide range of problems which children bring to institutions and indicate the awareness of individuals required of the institutional staff.

It has always disturbed me that houseparents are not generally given information about the children put in their care. These houseparents, or counselors, play such an important part in the daily life of the child that all their attempts are futile if they do not know how to meet him from the very beginning. Houseparents must increasingly take a professional attitude and accept information about children as confidential, and not the subject of gossip nor of indiscriminate remarks. To achieve this attitude houseparents must be helped to accept information without shock and as the basis of helpfulness to the child.

During an institute for houseparents one of the housefathers who worked in a training school said he did not want to have background information as it might prevent him from working constructively with a boy. I respect highly the honesty of this housefather, but I think he is not in the right profession. Only those who can accept the difficulties in the lives of the young people they serve will be able to help them. They should not be expected to do this without help. In an increasing number of institutions the social group-worker is used as a resource for providing such help. The more the essential importance of the living situation is recognized, the more institutions will respect the houseparent's job and give them the help they need for it.

Institutional Living

We have so far reviewed only the problems of the child as he enters the institution with his expectations and anticipations. What are his specific problems in living there?

Let us start with something which is unavoidable and which will be present in the very best institution. This is a certain amount of routine. Even highly individualized, small treatment institutions cannot avoid having more routine than the average family has. For a person who comes to routinized living as a healthy, happy individual as children do in summer camps, this is actually no problem. But the child who is mixed up emotionally has great difficulty in leading an orderly life.

Order in things can symbolize inner order. Undoubtedly it is helpful for a disturbed and upset child to experience a calm and orderly atmosphere. It is good to know when a meal is on the table, to be sure that there is a place where you can keep your clothes or some beloved toy, and to know when a certain person is available. But if the institutional atmosphere becomes rigid, then it becomes a straitjacket instead of a help.

I remember a treatment institution where you could feel the serenity and kindness of the staff. There a child's cabinet drawers bore silent testimony as to the length of a child's stay in the institution. In some drawers clothes had been thrown in a ball, and stockings mixed with handkerchiefs, and in others everything was in neat and careful order. One of the houseparents told me that practically all the children start out untidily.

"If we would push them, they would hate us" he explained. "But after a few weeks when they have calmed down a little we begin to straighten out some cabinets for them. Sometimes even an older child or one who has been in the institution longer does that. They are surprised when they see it; they learn that drawers close a little easier that way. Slowly, with some reminder they change as their inner calm increases."

How long to let untidiness go unnoticed, or how long to ignore troublesome eating habits, may seem like trivial problems. To the child and to the houseparent, they are most important, and sometimes they are far more important than an hour of individual therapy.

Food is basic for all human beings, but it has added importance for those who have been deprived. The institution's cook is a crucial personality. He must be not only a top cook, but one of the kindest and most understanding of human beings. Fortunately such cooks do exist. In one of the children's homes I know, the cook has become the stable center of the institution. She constantly tries not only to improve her skill as a cook—she has taken special courses in cake decoration and in French cooking—but also to increase her understanding of the children for whom she works. One of my real privileges was to have her in a course of mine. She has the great gift of understanding when a child needs a special dish or when it is important to let Susie hang around the kitchen and snitch something from the table even if she does not eat at mealtimes. She is infinitely patient in letting Tom and Johnny try their hands at making fudge even though they are slow and messy.

To the child in the institution a gleaming kitchen where nobody is allowed to enter, where the food comes from a steamtable, where there is no individual

A houseparent, who believes in the importance of children's relationships to each other, helps two boys settle a dispute.

attention, can be a damaging thing. In an institution for delinquents I saw the food being slapped on the plates and all mixed together. During the meal the children could not talk to each other because of the noise coming from the kitchen. At the end of the meal leftovers were dumped into one plate and removed. The children were not only deprived of any opportunity to learn table manners but were having their human dignity violated by being fed like cattle.

Another basic human need is sleep. Arrangements for this too can be helpful or harmful to children. Going to bed means much in a child's life. All children have times when they are afraid at night. More reassurance, therefore, is needed in the evening. I will never forget the 13-year-olds, very independent young men during the day, who begged me to tuck them in at night. But evening also brings a greater opportunity for intimate understanding. In a loving family, bedtime is the hour of closeness between parents and child. There is fun for the young child in splashing around the evening bath, and having a story read aloud. The older child may use bedtime as a time for talking over things with someone he likes.

Sometimes evenings become torture and a tug of war for children in institutions. It is not always easy for a staff to give institutionalized children the understanding they need for in the evening they often become extremely upset and destructive. The boys are apt to run around a lot and the girls to giggle. Creating a calming atmosphere requires individual understanding and skill. I have seen the relaxing influence of soft music played by a counselor (not by the impersonal radio or record) or of a story read in a soft voice.

In considering the problems of institutional life we have often focused exclusively on those arising from the relationship between the child and the staff or from the institutional routines. But the children face three additional problems: (1) *their relationship to other children*, (2) *coming to terms with their own inner emotions and their behavior*, (3) *their relationship to people outside of the institution.* Let us look at each.

The Need for Privacy

One of the most important facts of institutional living is that the children are together with contemporaries not of their own choosing. Each child has to adjust in some way to children he has never seen before, who may or may not like him and whom he may or may not like, and with whom he will be constantly thrown. Very few adults enjoy being exposed 24 hours a day to other people.

A housemother in a State training school for girls helps to create a calm, intimate atmosphere by playing for two girls.

Too many of our institutions have left no room for such privacy. They have put a premium on "adjustment" which is not really adjustment but a horrible submission to a constant beating down by the emotions, wishes, and pressures of others. True, most of the children coming to institutions today need help with relating to others and, therefore, the group situation is very important for them, but this does not mean that they should be fed with it constantly. Many institutions have forgotten that many human beings need to learn to be able to be by themselves.

I say this with some caution, for the theory has sometimes led to very cruel handling of young people. Solitude has too often been used as punishment, by putting the upset youngster or the newcomer into solitary confinement. I cannot be sharp enough in denouncing this practice. When a child's emotions are aroused and he feels guilty, he might need a few minutes of calm, but he will achieve this best through warm and sympathetic contact with a calm and understanding human being. Being forced to sit alone in an empty room is not only cruel but also defeats all purposes of rehabilitation. Some institutions routinely put new youngsters in isolation first. What a twisted approach to young people in distress! At a time when it is important for them to feel that there are people who care for them in spite of their having made a mistake and when they need help in regaining their self-respect such institutions submit them to a humiliating experience instead of to warmth, understanding, and companionship.

When I talk about the need for privacy I do not mean punishing isolation. I *do* mean having the opportunity to be alone, to be in a pleasant room with a book or with one's own thoughts. I mean a balance between activity and companionship in the program and the chance to withdraw. Single rooms, of course, are not always possible and are not even appropriate for younger children who have many fears at night. But the institution should provide some place where such a withdrawal is possible without becoming the "quiet room" which too often is nothing but a punishment cell.

The torture of constant interaction with others was well expressed by a 15-year-old who told me after a violent temper tantrum: "What can I do when I get mad? I would like to go off by myself and get it over with, but I am not permitted to do so and there is no place for it."

For the teen-ager larger-dormitory living increases tension. Adults have found such mass living to be one of the hardest chores of army life. Yet our draftees at least know their situation is temporary; most of them recognize the necessity of it; and they are not disturbed people in the first place. To demand such life of children is asking too much.

Children's Relationships

Relations between contemporaries are difficult. The institutional staff must be sensitive to the different ways in which youngsters are accepted or rejected by each other. The constant attention of a housemother to a particular child has sometimes made it impossible for the child to become a member of his group, which looks upon him as a "teacher's pet." Even when an especially deprived child needs an adult's special attention the houseparent must be alert to the atmosphere in the group and give all the members enough attention and status so that they will not hurt the deprived one.

It is possible to discover unusual leadership capacity in a child by watching the way he is accepted by contemporaries. A boy who seemed extremely solemn in his relationships with adults and who at first glance seemed withdrawn from others was selected by the other children as the person they would like to represent them on a council. What had happened? More sensitive observation revealed that this boy who seemed so withdrawn was really a leader. In an unobtrusive way he helped other youngsters find their things when they had lost them or he told them that something was not right to do, or he calmed a frightened newcomer. He did this without showing off. Staff members must sharpen their observations to give such youngsters opportunity to increase their leadership capacities.

The possession of private property is of great importance to a child. In entering the institution he is apt to feel that he has lost some identity. He must be helped to feel again that he is an individual in his own right. To have clothes closets in a basement so that a child cannot reach for his own things when he wants them is to subtract something from his individuality. Institutions have moved away from uniforms but few of them allow children to help select their own clothes.

It is extremely important for a youngster to feel that there is some place where he can keep his most cherished possessions where others cannot get at them. I shall never forget an institution which was very proud of the fact that each girl had a little locker for her own things. Yet, as I was being taken through the dormitory, the superintendent threw open all the cabinets to let us see how the girls kept them. What is the use of a private place if everybody has the right to look into it?

How different was the delightful experience told by a young nun who had helped the boys to make their own lockers and put locks on them so that nobody else could look into them. One day one of the boys came to her with a beautifully made box and said, "Sister, I made this for you. You don't have any place to put your things either."

Coming to terms with oneself is perhaps the hardest task for all of us, and we cannot expect our children to achieve it perfectly. But the child who is frightened or the child who is confused needs badly to gain some insight into himself. Some of this can be achieved through individual casework treatment or through psychotherapy. But some of it must be handled in the group situation.

I do not expect the houseparent to take on the role of a therapist. But a good houseparent cannot completely reject responsibility for discussing some problems with his youngsters. When a child has shown fears and resentments in a group situation it helps him when the trouble can be talked over immediately in a sympathetic way. Sometimes the other children in the group can give helpful insights. Skill and judgment are needed for knowing when this is possible and necessary or when it is more helpful to ask the youngster to wait for a treatment interview. We cannot close our eyes to the fact that many institutions have insufficient individual services. One of our responsibilities is to increase them. Another one is to help those persons responsible for the quality of group living to learn more and more how to help youngsters gain simple forms of insight into themselves.

Feelings About Parents

Another hard problem is the child's relationship with the parents and relatives he has left outside the institution.

The social caseworker is the one who carries the main responsibility for keeping these relationships alive and helping a youngster to work through his feelings about them. But an individual cannot be cut up into separate compartments. The child carries his problems of family relationships with him at all hours of the day. His relationship with his parents may be influencing his relationship with his contemporaries. He may feel he is losing status because somebody has found out that his father is in jail. Or a young girl may live in terror because the others may find out that her mother is in a mental hospital and think she is crazy too! Such feelings color institutional behavior.

Martin Gula of the Children's Bureau once asked children who had been in institutions what they expected most from houseparents. One answer was a strong plea not to talk badly about their parents. Houseparents may not mean any harm when they do this. They may only want to let the child know he is not to blame for being in the institution because his parents were so "bad." But most children resent this. They show their resentment in different ways.

I remember Liza who constantly talked about her lovely home and her kind mother and understanding father. All of us knew that Liza had been brought up by a cruel, promiscuous grandmother in a rundown tenement. But Liza knew no other way of coping with her dreadful homelife than to pretend that it did not exist and to fantasy another one. The kind and understanding housemother never called Liza to task for this. She helped Liza to feel more secure in herself, to learn skills, and to stand on her own feet, while the caseworker let Liza talk out some of her despair. With this integrated approach, Liza gained a sense of worth and of security so that she did not need to pretend any more.

It is also extremely important to help youngsters to find some achievement in institutional life. Kindness, understanding, and opportunity to talk out and to make friends are not enough if one cannot feel that one can achieve and give to others. This means that we must learn as soon as we can about the capacities of each youngster with us and try to help him develop these. Achievement may come in school, or in group activities outside of school, and sometimes through individual initiative.

Science and Love

Those of us who work in institutions must develop an attitude of scientific inquiry as well as warm, human understanding.

At the same time we must increase our love for people and our understanding of them even if they make mistakes.

I cannot close without saying that institutional life holds not *only* problems but also gratifications, happiness, and a movement towards health for many children. Children come to institutions with problems—otherwise they would not be there. They face problems—otherwise they would not be living. But if we who work with them understand them, if we give them our deep respect, and our love, we will help them not only to a constructive but also to a *happy* life. Sometimes we forget that one of the most healing experiences is laughter and enjoyment. If we can add this to life in the institution we will be rewarded by seeing children become mature personalities in the beautiful sense of being "happy and responsible."

We talk about the problems our children face and what *they* must learn. But they can learn only if we who work with them, learn too not to be mean or petty or small and to allow for tears and laughter, for serenity and joy.

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suggests that a related factor may be lowered resistance due to poor nutrition, though this has not been scientifically established.

Slipped epiphysis, a rather frequent orthopedic
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dolescents or adolescents. In this, too,
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The emotionally disturbed child may reflect his emotional upset in a poor nutritional condition. He may develop a feeding problem or a variety of feeding problems as a result of his emotional tensions—digestive upsets, loss of appetite, overeating, capricious or bizarre food selections, or pathologic fears of certain food textures. This last problem is frequent in post-polio patients, who are often afraid to swallow even when muscle power returns, and in some children with cerebral palsy who have never had an opportunity to cope with solid foods.

Loss of appetite is a frequent problem in crippled children. It may be caused by physical illness or inactivity, or post-paralytic mechanical difficulties in emptying the bowels. In many instances, fatigue is the primary cause. The mechanics of eating may be almost overwhelming.

Meeting a Challenge

There is scarcely a child under care in a crippled children's program who would not offer a challenge to a competent nutritionist. The case of Janet R. illustrates how such a challenge was met.

Janet was a 13-year-old girl known to a crippled children's service from the time she had had osteomyelitis—a bone infection—at 7 years of age. She had been coming to the orthopedic clinic for routine yearly followup, and was progressing well, walking unaided except for a ¾-inch lift on one shoe to compensate for a short leg. At the time of her most recent visit, the orthopedist's only recommendation had been to add a quarter of an inch to the shoe lift.

Within a month after this visit, the school nurse and teacher sought the help of the public-health nurse. Janet was doing poorly in school, had had several spells of unexplained weeping, seemed chronically tired, and had lost weight. The school physician found no pathology to account for these changes, but he did learn that Janet had grown rapidly during the previous year.

An alert teacher picked up the first clue as to the nature of Janet's difficulty. In biology class she noticed that although Janet seemed unusually interested in finding out how long growth in height continued, she seemed embarrassed in asking her questions. The teacher thought about this and discussed her observations with the school nurse and the public-health nurse. Together they awoke to the concern that Janet was having about her own rapid growth, and her fears that, as she later managed to tell the school nurse, she might "grow more than her leg would." In a misguided effort to prevent disparity in leg length, Janet had been starving herself.

Once the problem was defined, the school health group worked with the orthopedic-clinic personnel to assemble facts and interpret them to Janet. She was helped to a better understanding of normal adolescent growth and its relation to general health. The orthopedist reviewed her bone X-rays and taking into consideration that her menstrual periods had started, told her with some assurance that she was close to completing her growth in height.

Meanwhile the public-health nurse sought the help of the nutritionist and the school nurse. Together they recognized that the primary problem was not the minor orthopedic defect, but the critical need of safeguarding the health of an adolescent girl. The school nurse not only worked with Janet, but also collaborated with the biology teacher in carrying out a health education project on adolescent nutrition pertinent for all the students in her age group.

Cleft Palate

Certain types of crippling conditions such as cleft lip and palate occur so frequently that it is well for a nutritionist to join the rest of the treatment team in drafting general principles of care, which can then be individualized for each patient. Cleft lip and palate patients present a challenge to nutritionists not only because they comprise a considerable segment of the handicapped child population, but because poor nutrition is inextricably related to the condition.

Since this is a congenital anomaly, prematurity, with all its nutritional handicaps, is likely to be a complicating factor.[2] Premature babies have the same nutritional requirements as fetuses for rapid growth—extraordinarily high protein, minerals, and ascorbic acid and other vitamins—in the face of low stores of essential proteins, minerals, and vitamins; weak or absent sucking reflexes; tendencies to distention and regurgitation; low gastric acidity; poor fat absorption; and an incomplete digestive-enzyme system. In addition, these babies must cope with the very real handicaps the cleft lip and palate present to the eating process.

A nutritionist has much to contribute to the nurses and doctors treating a child with cleft lip and palate, especially during the critical period of infancy. To their skill in feeding premature infants nurses must add the ability to cope with the problems introduced by the structural flaws of the mouth. The feeding difficulties in such infants are a complex combination of the mechanical, the physiological, and the psycho-

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logical. They must be skillfully dealt with if the child is to be well launched in his physical and emotional growth, and if he is to be in adequate condition to withstand and profit by the required surgery and to meet the subsequent demands of tissue healing on which the success of the surgery depends.

The nutritionist is an equally valuable member of the cleft lip and palate treatment team for older children. Consider the case of Danny G.

At 6 years of age Danny was no taller than his 4½-year-old brother Joe, and was slighter in build with smaller muscle mass, and less subcutaneous fat. He had already had four operations, starting with a lip repair the week he was born. Three attempts at palate closure had failed. The record summary read: "Closure was attained in the operating room, but the tissues failed to hold."

The nutritionist first knew Danny through the public-health nurse who asked for nutritional guidance in her work with the G. family, which was under financial strain. There were five children in the family, Danny being the middle child.

Mr. and Mrs. G. accepted crippled children's services for Danny, but insisted on participating financially, saying proudly that they could "manage." Even the briefest review of their budget realities revealed that the way they "managed" was to manipulate practically the only expense item susceptible to their influence—food. Mr. G. proudly called this "tightening the belt." The actual contents of their market basket were mute evidence of fortitude, frugality, and family malnutrition.

Because Danny was having one cold after another, the parents asked the public-health nurse for "something to build him up." The nurse turned to the nutritionist for help, and working with her and the medical social worker, made plans to help not only Danny but the entire G. family. They realized that because of his cleft lip and palate and repeated upper respiratory infections, Danny needed a high caloric, high protein, high mineral, and high vitamin diet, in a form which he could manage mechanically. That is, he had to have food that he could chew and swallow, which would be relatively nonirritating to his sensitive and exposed nasopharyngeal membranes. With this in mind, they worked out a therapeutic diet in detail for Danny, and then converted it into a plan for family feeding designed not only to improve the nutrition of the whole family but also to tie Danny more and more closely into the family group, so that he would not suffer the additional handicap of being isolated by a special diet.

The nurse and nutritionist did not stop with those accomplishments. They also translated the entire family dietary requirements into the realities of food costs in their own community and the size of the G. family's pocketbook. The nurse then worked with Mrs. G. in long-term practical application of the whole treatment program.

Speaking about the experience later at a staff meeting, the nurse said: "It seemed to me that I had never spent so much time in my life on one boy's and one family's feeding problems. I felt as though I could not afford that much time. Now I realize that that time was not an expense but an investment and not just for the G's either, but for my other families. Danny is better than he has ever been, and the other children are thriving. I find I have been passing nutritional advice to other families. Good nutrition is real to me now. I actually see it in terms of meals and market baskets."

Hearing Loss

In addition to their other handicaps, children with cleft lip and palate often have to struggle with progressive hearing loss from repeated ear infections. Anatomic distortions of the nasopharynx make them susceptible to repeated infections of the nose and throat which may spread through the Eustachian tubes to the middle ears. Soon a vicious circle is set up. Respiratory infections are followed by secretory otitis media, general debility, and increased demands on an already inadequate nutritional reserve, and so greater susceptibility to colds.

Children with cleft palates are by no means the only group who go through this vicious circle resulting in progressive hearing loss. Many school-age children under care for hearing loss have chronic middle-ear infection similarly produced. The condition calls for a variety of services from crippled children's programs. The experience of Carmen E. is an example of the place that a nutritionist has in the constructive care of children whose hearing has been impaired by such infections.

Carmen was the 9-year-old child of Mr. and Mrs. E. She was the third of seven children, and had been described at birth as a "normal female infant of 7 pounds." Through her first year and a half her mother took her regularly to a well-child conference, and during this time she grew and developed well. Later, the public-health nurse noted on home visits that, since Mr. E. was able to get work only irregularly, the family was short of food and were eating little else than beans, rice, and miscellaneous starches.

Carmen started first grade at the age of 6. For the first half year she was a noticeably alert, eager little girl. Then followed a period when she was described as "never free from a heavy head cold." The public-health nurse and teachers believed that the child's diet was meager in quantity and even poorer in quality.

In second grade Carmen began to daydream, and to appear disinterested much of the time. Through routine group audiometry she was picked out as having a hearing loss in the speech range, which was confirmed subsequently through an individual test. An adenoidectomy and a tonsillectomy were recommended.

Carmen's family did not follow through on this recommendation, apparently because Mrs. E. herself was ill.

The following year another hearing test in school revealed further loss. The recommended surgery was then carried out through the local crippled children's agency and Carmen's hearing improved for a brief period. Soon thereafter, however, a new series of respiratory infections began and her hearing loss increased until, in less than a year, the crippled children's agency received a request for another adenoidectomy.

Though this cerebral-palsied child expends considerable energy in getting food to her mouth she manages her eating well. Others, however, have so much difficulty that they become too tired to eat enough to provide good nourishment

After accepting her case tentatively for diagnostic study, the agency found that Carmen suffered from "chronic malnutrition, dental caries, fatigue, nutritional anemia, and subsiding purulent otitis media."

Surgical activity was deferred and a treatment program worked out jointly by the pediatrician, dentist, public-health nurse, and nutritionist with the help of the school welfare worker and the family. Carmen was given 6 months of concentrated care in the form of dentistry and antibiotics and general health supervision including dietary attention involving a high caloric diet, rich in proteins, minerals, and vitamins. At the end of 6 months her general condition, as well as her hearing, had noticeably improved.

Cerebral Palsy and Polio

The role of the nutritionist is equally important in two other large categories of crippling conditions affecting children—cerebral palsy and poliomyelitis.

In cerebral palsy, as with cleft palate, many of the patients begin life as premature babies, with all that that implies nutritionally. Here, too, the defect itself poses certain nutritional problems. Children with cerebral palsy, especially athetoids and tension athetoids, use a great deal of energy in the ordinary routines of living. Because of their uncontrollable bodily motions or tensions, they may require a caloric consumption as high as 3,000 calories per day for simple maintenance. These involuntary motions and tensions make eating painfully difficult, owing to the fatigue and frustration involved in moving food from the dish to the mouth. Chewing and swallowing are laborious processes and can be exhausting to the patient and to those trying to help him. The whole feeding procedure is often embarrassing to the patient, and often swallowing difficulties and a tendency to choke are very frightening to himself and to others.

Such difficulties have often led in the past to an excessive use of foods of puréed consistency, likely to be carbohydrate in nature, and certainly with little or no chewing value. The result is that gross nutritional deficiencies, as well as dental and gingival diseases, are found in most cerebral-palsy patients.

Modern nutritional management for the cerebral palsied makes every effort to get away from liquid and semiliquid fare and to help the patient progress to such solids as he may be able to chew and swallow. While consideration should be given to the great energy consumption of these children they should not be fed carbohydrates at the expense of other essential nutrients.

Polio presents its own set of nutritional problems, principally of two kinds: undernutrition and obesity. The post-acute condition involves the nutritional demands of any convalescence from an acute illness, complicated in paralytic cases by special difficulties. Respirator cases particularly present a problem of complicated feeding mechanics. Patients who have or who have had difficulties in swallowing often are afraid of choking. This has to be taken into consideration in planning their meals. Similarly, consideration must be given to the special difficulties of palatal paralysis which causes food to regurgitate into the nasopharynx. Foods for polio patients have to be not only nutritious but provided in a form which the individual can consume without undue fear or danger.

The process of eating causes great fatigue in many post-polio patients. There is fatigue of the muscles of chewing and swallowing plus the bodily fatigue resulting from the struggle of lifting the food from plate to mouth. The strain of the feeding position itself may be exhausting. Older children, especially adolescents, may be reluctant to go through the arduous feeding process in the presence of observers.

One contributor to undernutrition in polio patients as well as in other handicapped children is the frequent habit of their relatives and friends of plying them with sweets and delicacies, which diminish their appetite for essential foods. This food-treat problem is also involved in the problem of obesity, largely caused by excessive and inappropriate intake combined with various degrees of sedentary existence.

Obesity in any child brings problems because of its effect on health, normal activity, and perhaps on personality development. It presents an added problem to the crippled child because of the difficulties of weight bearing.

The role of the nutritionist in dealing with obesity in polio-paralyzed children is similar to her role in dealing with obesity in any group of handicapped children, and especially those with slipped epiphysis. She has a dual task in prevention and treatment, and in carrying it out she can set the tone for the whole treatment team by designing realistic plans and avoiding a punitive, scolding sort of approach and the tendency to make weight-control advice generalized and meaningless.

In one orthopedic clinic, staff members had for some time been warning an obese adolescent girl to "watch her diet" and "be careful." When the girl continued to gain at a rapid rate, it was discovered that she was getting along on a meager breakfast, and doing without lunch, but was eating quantities of cooked rice and other starchy food at the evening meal. There were very few minutes in the entire day when this child was not actually hungry, and she was doing exactly what she thought was meant by "watch your diet."

The nutritionist can be a source of great help in such a case through her ability to recognize the patient's indispensable food requirements, and to see that these are recommended to her with at least as much diligence as calory deletions.

Many other crippling conditions call for nutritional services. Among them are severe burns. Here the nutritional demands involve maintenance of the child's life, his further growth and development, recuperation from the generalized damages of the burn, healing of the burn itself, and the capacity to withstand and profit by such surgical repairs as may be required.

The Nutritionist's Role

The nutritionist in preventive and treatment work with crippled children does not function primarily in direct service to the patient. She is part of the treatment team, participating in the team's major relationships to the patient, to the program, to the personnel of the agency, and to the community.

Except for carrying an occasional case on a demonstration basis, she works indirectly as a consultant to those rendering direct service in casefinding, the furtherance of general health care, and in treatment and followup.

She also plays an important role in program planning, in inservice training and staff development, and in the preparation of educational material.

Primarily a consultant and demonstrator, she works a great deal with the public-health nurses and with the medical social personnel.

The nutritionist's relationships to the community include collaboration with hospital dietitians as consultants to other community groups concerned with children's health, education, and welfare.

In fact, the potentials for nutritional services in crippled children's programs are almost boundless.

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[1] Johnston, J. A.: Nutritional studies in adolescent girls and their relation to tuberculosis. Chas. C Thomas, Springfield, Ill., 1953.

[2] Dunham, E. C.: Premature infants; a manual for physicians. New York. Paul B. Hoeber, Inc. 1955. (p. 158–208).

Michigan demonstrates through more than nine years of experience that . . .

CHILD AMPUTEES CAN BE REHABILITATED

CHARLES H. FRANTZ, M. D.
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ONE OF THE TRAGEDIES of our current society is the apparently increasing number of children who are minus one or more arms or legs because of amputation, suffered either congenitally or as a result of accidental injury.

Trauma, infection, and tumor are leading causes for amputation in children, but trauma is far in the lead. The peregrinations of youth lead them into hazardous situations. They are passengers in high-powered autos. They are bicycle riders on busy highways. They are exposed to mechanized vehicles on farms which too often do not have adequate safety devices. Adolescent boys, and even younger ones, are too often allowed firearms which in the absence of mature judgment and precautions result in mangled limbs necessitating amputation.

An analysis of 300 children seen in Michigan during a 9-year period with amputations classified as noncongenital revealed that over 65 percent were the result of trauma. Slightly over 40 percent of

At 13 years of age this active boy, who has a below-elbow amputation, has been wearing a prosthesis since he was 6. A skillful user, he competes in various types of sports. Here he is wearing a baseball attachment on his prosthesis.

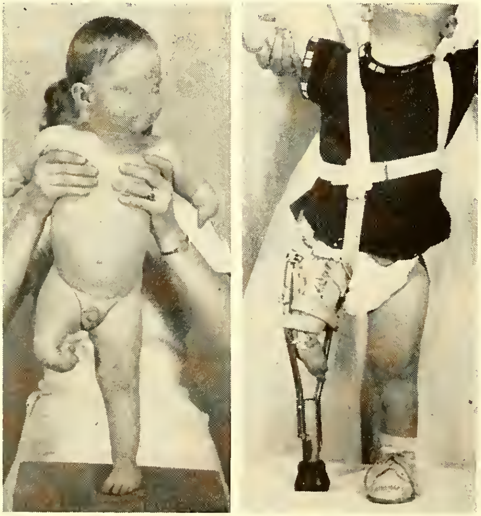
the amputations were the result of railroad, power-tool, and vehicular accidents; and 20 percent were the result of explosions and gunshot wounds. These tragic accidents were in many instances avoidable. Greater efforts must be made to prevent others from occurring.

Fortunately, however, children who have suffered amputations are not crippled in the same sense as the post-poliomyelitis victim or the cerebral-palsy victim. What is left of the limb in the young amputee is normal. It gives him a great potential for rehabilitation.

Children with congenital amputations come close in number to those with post-traumatic amputations. In a few years, as casefinding improves, they will probably comprise 35 percent to 45 percent of the total number of cases.

Congenital amputees are usually in the younger age groups when admitted to a training unit. This is quite understandable, for treatment for the amputee who is born with his condition should be sought at an early age. On the other hand, the traumatic type of amputee does not appear significantly in statistics until he is 6 or 7 years of age, the age when children begin to wander farther from the home environment and so are more apt to get into trouble. The incidence of post-traumatic amputations rises from then through the teen years.

This child with triple congenital anomalies received his first prosthesis at 20 months of age and learned to walk soon after.



These facts have been revealed by 9 years of study of the child amputees at the Mary Free Bed Children's Hospital and Orthopedic Center in Grand Rapids, Mich., which, under the auspices of the Michigan Crippled Children Commission, opened a Juvenile Amputee Training Center in the early fall of 1946.

Young amputees from the State of Michigan are referred to the center. They come with and without prostheses. The vast majority of these young amputees have been operated upon by surgeons throughout the State. In the 9 years since it started, a total of 300 patients have used these services. These are now being extended to children of other States through the use of special funds from the Children's Bureau, U. S. Department of Health, Education, and Welfare.

The Training Center is available to children from all walks of life. They may come on a paying basis or under the auspices of a State crippled children's agency or a voluntary philanthropic organization.

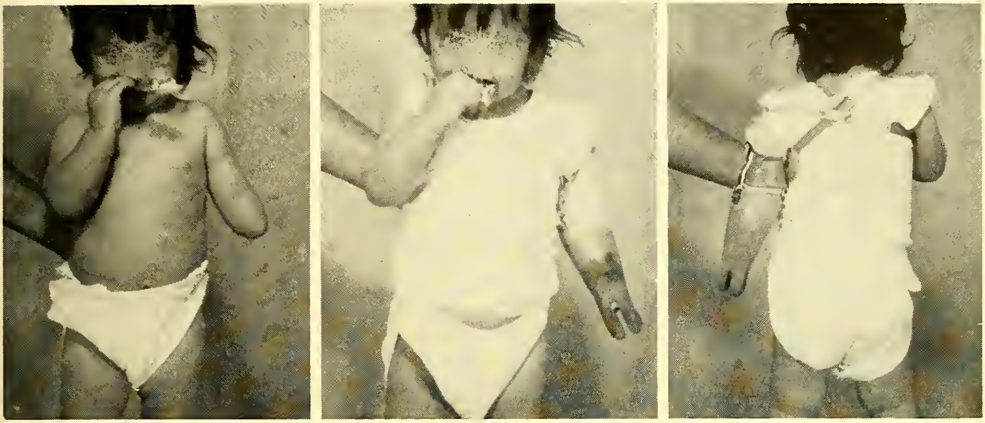
Fitting and Training

On admission to the outpatient clinic the patient is examined by a team: orthopedic surgeon; physical and occupational therapists; prosthetic instructor; and prosthetist. If the child already has a prosthesis but is a poor wearer, the reasons why are searched for and corrected. If he is a fresh amputee with no prosthesis, the necessity for stump conditioning through occupational and physical therapy is determined and a program outlined for this. A prescription for the prosthesis is then written.

During the interval in which the prosthesis is being made the child may remain as an inpatient for stump conditioning or he may be sent home with a program of exercises, depending upon his physical condition and home. When the new limb is completed, the child who has left the center is readmitted for fitting and training after an initial checkup of the mechanical standards of the prosthesis.

The therapists and prosthetic instructor give the young amputee a period of training which varies in time, depending upon the age of the child and the type of amputation he has. When the team has decided the child has achieved sufficient skill in using the prosthesis, the surgeon, after a final check of his performance, discharges the amputee to the outpatient clinic for followup care.

The outpatient followup care may be called the maintenance program. Visits every 3 months are



A 20-month old child with a below-elbow amputation wears a passive prosthesis to help her push and pull at normal distances from the body. In 2 months this was changed to one with a terminal device she could learn to open and shut.

to keep the prosthesis in repair and to accommodate for growth. The exertions of a well-trained young amputee will put a punishing load upon his artificial limb. This is esecially true of boys of elementary-school age. Children learn to grow up with their prostheses, which become much more a part of them than they ever do in an adult. Every effort is made to repair the prosthesis on the day of the outpatient visit as experience has shown it to be poor policy to allow a child to go without his limb.

The center's training program has evolved into seven closely correlated stages:

1. Physical examination and mental evaluation.
2. Physical therapy (if indicated).
3. Occupational therapy (if indicated).
4. Prosthetic fitting.
5. Prosthetic training.
6. Schooling and recreation.
7. Outpatient clinic followup.

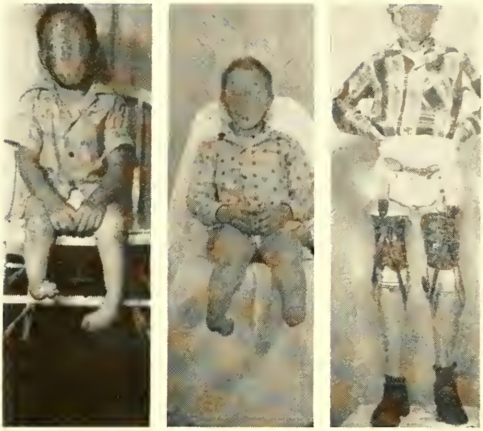
The young amputee is in the personal charge of the clinic team chief who is an orthopedic surgeon. Consultants are available. The pediatrician gives consultation most often in regard to congenital amputees. Observation has shown that where one anomaly exists there are often other abnormalities about the body not evident in the usual physical examination. Gastrointestinal and cardiac anomalies may accompany extremity abnormalities. Ophthalmologists are consulted if any question arises about eyesight.

The results of these specialized services have been gratifying. Juvenile amputees and their families have been shown the tremendous possibilities for future economic independence and the satisfaction of accepting and conquering a handicap early in life. Nearly 100 percent of those who come to the center with lower extremity amputations learn to wear and use prostheses. From 80 to 85 percent of upper extremity amputees wear prostheses. These figures are thought to be among the highest in the Nation.

Parents and Environment

Our experience has demonstrated that the posttraumatic amputee who once had normal extremities seeks rehabilitation much more readily than the congenital type of amputee. When the amputation has been the result of trauma there is little difficulty in pointing out to parent and child the advantages of a prosthesis. Having known normal function in the extremities, the young amputee is willing and anxious to be fitted and trained, as is his family for him. The goal is to come as close as possible to normal functional skills.

The full cooperation of each child's family is a prerequisite to his achieving success in the program. Not infrequently the parents of a child with a congenitally amputated extremity, particularly an arm, will hesitate in considering the application of a prosthesis. This is most frequently true of the mother. Her hesitation may stem from a deep-seated sense of guilt over possible hereditary factors



Born with deformed feet, this boy was first fitted with prostheses at the age of 5. One foot had to be amputated later, as it continued to grow. Now 11, he runs like other boys.

having produced the abnormal extremity. Such feelings become translated into a revulsion from the metallic terminal device offering prehension. The mother just cannot stand to have her child carry about a "repulsive-looking" appliance and so refuses to accept the handicap as such.

Many children born without a hand and a portion of the forearm—a very common type of anomaly—become skillful in handling objects in the crease of the elbow. The mother is quick to point out this accomplishment. However, without an appliance the child must operate as a one-handed individual, for the range of operation of the upper extremities is limited to an area close-in near the body. Fortunately the problem of a mother's hesitation is often solved by a frank discussion of the young amputee's future. Frequently, a child one or two years older than the child under consideration and with the same type of amputation but well trained in the use of a prosthesis will be called in to demonstrate his skill to the distressed mother. More often than not the demonstration will precipitate the mother's decision for acceptance of a prosthesis for her child.

Environmental factors, too, have great bearing on the child amputee's attitude toward his handicap. Entering kindergarten is a crucial step for the young child after the application of a prosthesis. Child amputees should attend a regular school. The teacher should be given instructions in the operation of the prosthesis and shown what it will do for the child. When she has this understanding she can more easily help the young amputee to fit into his environment and to become one of the group.

There is an important difference between congenital amputations and the malformed extremities. True congenital amputations do not present a problem in fitting with the conventional types of artificial limbs. On the other hand, the abnormal extremity, in which absence of the limb is only partial and malformed parts remain, presents difficult problems in proper fitting of appliances. Often the judgment of the surgeon is taxed. He must make a decision on whether removal of a part surgically will offer better possibilities for prostheses and thus greater function. Children with parts so removed are called "converted amputees," since abnormality is converted to an amputation. This procedure is never carried out if it presents a danger of function being sacrificed. Often a conversion is delayed for a number of years. During the interim the child is fitted with a modified type of prosthesis. Growth and functional skill determine the advisability of an eventual surgical conversion.

The complications from amputations that beset adults, such as spur formation (bony protuberances) on the bone stump, extensive scar formation, painful phantom limb, and excessively short stumps are not of great significance for child amputees. They are active, growing, adaptive, and cooperative little individuals who seldom complain of their stumps.

The one complication which does occur after amputation in childhood is the growth of the bony stump. The bone sometimes grows at a greater rate than the soft-tissue part of the stump. When it does, the bone end exerts pressure on the soft parts and may perforate the soft-tissue elements. This phenomenon, called "overgrowth," has to be treated surgically.

Time for Fitting

There used to be a tendency to postpone the fitting of a prosthesis to the child amputee. Children were left to go around on crutches or with empty sleeves, with the statement: "Wait a few years, until he can handle an artificial limb."

Why wait? In their normal growth and development children pass through very definite stages of motor skills. They progress from sitting, to crawling, to standing, and to independent ambulation on a definite, predestined time schedule. While there is variation in the chronological progress among children, most children learn to walk between the ages of 8 and 15 months. From the age of about 18 months they perform progressively skilled acts with their hands. The youngsters' potential dexterity becomes near the adult's at about the age of 8 years. Increased skill from then on comes from experience and finer coordination.

The child born with an abnormally short or partial absence of an extremity has the same time schedule for standing and walking as a normal child. An appliance should, therefore, be fitted to the toddler when he attempts to stand. When it is, he will soon "take off" independently.

We have found that babies as young as 6 months will tolerate a passive type of upper-extremity prosthesis. This helps them push and pull at normal distances from the body. With it, they will hold dolls and utensils on the fitted side. Children as young as 24 months have been taught to operate a terminal device which they can open and close at will. Several young amputees with the arm off above the elbow have mastered the terminal device and a mechanically locking elbow joint at 33 months of age—an accomplishment demanding considerable
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The advance has come about largely through the efforts of the Advisory Committee on Artificial Limbs, of the National Research Council. The Orthopedic Appliance and Limb Manufacturers Association has cooperated with the Council in research on the child amputee. The College of Engineering of the University of California, Los Angeles, has recently developed a superior type of upper-extremity prosthesis providing better function in general performance than any heretofore available.

The research and development of children's appliances at the Army Prosthetic Research Laboratory at Walter Reed Medical Center, Washington, has produced devices allowing a greater latitude in the fabrication of prostheses than ever before known.

For the past 2 years the Mary Free Bed Children's Hospital and Orthopedic Center has conducted a monthly upper-extremity research program with the Research Division, College of Engineering of New York University.[1] Detailed observations on the types of prostheses, harnessing, individual performance, and progressive skill of young wearers have been carefully recorded. Parents as well as young amputees have been interviewed in an effort to determine family reactions to each type of prosthesis, the psychological adjustment it necessitates on the part of the wearer, the child's attitude toward his disability, his social sensitivity, and his overall accomplishment.

Close to ten years of experience with child amputees in Michigan has led us to the conclusion that the child amputee generally has great potential for complete rehabilitation. Properly fitted with a prosthesis and trained to use it, he can develop into a productive citizen. The establishment of child-amputee centers in California, Illinois, Wisconsin, Minnesota, New York, Oklahoma, and other States is an encouraging sign of a growing recognition of his needs.

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[1] National Research Council, Advisory Committee on Artificial Limbs, Report No. 3, 11517, June 1955.

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An experiment to promote discussions of . . .

PARENTHOOD IN A FREE NATION

ETHEL KAWIN, M. A.

Director, Parent Education Project, University of Chicago

WHAT KIND of parent education is needed to help parents bring up mature, responsible citizens, able to function in and maintain a free society?

This was a major question to which the Fund for Adult Education, established in 1951 by the Ford Foundation, was seeking an answer in the summer of 1952. To this end the Fund invited a group of professional workers with special experience in parent education to a 2-day conference.

The Fund asked for suggestions in developing and trying out in experimental programs, materials, and methods of presentation designed to help parents become and bring up mature, responsible citizens. It wanted materials intended for ultimate use as media of education in *study-discussion groups* for parents in which considerable responsibility would be placed upon volunteer and lay leadership and upon all members of the group.

As a result of these exploratory discussions, the writer was asked by the Fund to outline a program for a parent-education project. This became the basis of the University of Chicago's Parent Education Project, later set up by a 2-year grant from the Fund. It was initiated in April 1953 and extended by a further grant when the 2 years had expired.

The planning of such a vast and ambitious program might have been approached in various ways. We decided to try to begin with "major essential characteristics of mature, responsible cit free society." This posed some f questions:

What foundations of growing pe behavior enable a child to become th who can function successfully as democratic society? What ides of parents help to bui hild?

has been no researcl revealed the kinds of personal qualities, capacities, and skills required for competent participation of the individual in a democratic social system. Certainly, there is need for thorough and systematic basic research to identify such characteristics and abilities, but it is doubtful that present-day methods in the social sciences are adequate for the task. In any event, such basic research would be beyond the Project's scope.

Laying the Groundwork

However, research studies have thrown some light upon various aspects of these major questions. the basis of such studies and the general acce of certain assumptions for the purp ect, six major characteristics of m citizens in a free society were i mitted to the judgment of scholars for comment and arrive at an agreed-up panel were eight pr parts of the co psychiatry, ment, educ because underst ciall

The basic course is designed to help parents acquire a philosophy of parenthood. Under the six major topics, the course offers for study and discussion general concepts and principles that have important implications and applications for the daily life situations of parents and children. The Project has prepared six basic readings, one for each of the six major topics. A great amount of research material was analyzed and evaluated in the preparation of these readings. They are published in a 130-page illustrated experimental edition entitled "Parenthood in a Free Nation."

Supplementary Materials

Each basic reading is followed by a list of supplementary pamphlets dealing with the topic under discussion. Additional reading references are included for those who wish to read more widely.

A suggested discussion guide was developed for use with each topic. After being tried out and found helpful, the guides were included in a manual published as a companion booklet to the basic readings. Groups may follow them carefully if they wish, but many use them only to stimulate discussion.

Selected films are included among materials which may be used with "Parenthood in a Free Nation." The manual contains a suggested outline for film discussion for each film selected.

The basic course is to be followed by five supplementary courses adapted to various periods of child development. In each of these, concepts of the six major topics will be reconsidered for their specific implications and applications for guiding children through the various age periods. Ideally, a young parent begins with the basic course and over the years, as his children are growing up, continues with the five age-period courses in sequence. Or, after the basic course, a parent may enter a course concerning the age group of greatest interest to him. These courses are designed to help parents acquire knowledge of children's needs and behavior at different stages of development and understanding of how to apply it in guiding their children.

Each course is designed for study-discussion groups in which participants, after study, discuss the topics in a series of 8 or 10 meetings of about 2 hours each. The course begins with an introductory meeting in which its general plan and content are presented by the leader and discussed by the group. The closing meeting is used for summarizing and evaluating the course, and for discussion of subsequent courses. The intervening meetings are devoted to the six major topics. Many groups find that they want to spend more than one meeting on some topics.

The general plan suggested for Parenthood in a Free Nation courses departs somewhat from the procedure of discussion groups in which all members share equally the responsibility for the program of each meeting. The Project's plan suggests that at the opening meeting the group divide itself into six subgroups, one for each major topic. Each subgroup accepts responsibility for planning the presentation of its topic at one meeting of the total group. By thus participating in planning, every member becomes actively involved in the program from the very first session.

This procedure divides responsibility for intensive preparation among all members of the group so that each individual has a major responsibility for one meeting, but each member participates in all meetings. Each subgroup has about 20 minutes to present its topic, using any type of program that it wants, such as a symposium, panel, roundtable, film forum, "buzz" session, or dramatization. Whatever the type of program, its purpose is to stimulate discussion by all members of the group.

One of the criticisms frequently made of discussion-group programs, especially those with lay leadership, is that they are likely to remain at a rather superficial level if no one in the group has much knowledge of the subject or a wide background against which to discuss it. Most members of voluntary discussion groups are too busy to read widely on a number of topics, but experience in Parenthood in a Free Nation has shown that they usually will find time for fairly wide reading and thorough preparation on *one* topic. Most evaluations from experimental groups using the Project's plan expressed marked preference for this subgroup organization and procedure.

Experimental Programs

The various materials and methods developed for Parenthood in a Free Nation have been evaluated through a series of tryouts—by a group of graduate students in education at the University of Chicago, by five groups in Illinois communities, and in a nationwide experiment which became international when several Canadian organizations a

A workshop to train leaders for
perimental program was held at
Chicago in August 1954. Its me
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discussion groups of parents and teachers. They came as representatives of 28 sponsoring organizations interested in parent education. They represented public schools, State departments of education, universities and colleges, adult-education organizations, community and family service agencies, parent and teacher groups, mental-health societies, private health agencies, religious-education organizations, and farm bureaus. Each organization, in accepting the invitation to the workshop, agreed to form at least three experimental study-discussion groups to try out Parenthood in a Free Nation in its own community the following autumn.

The Tryouts

Approximately 100 groups, located in 18 States and 2 Canadian Provinces participated in these experiments. The 2,000 participants included persons from a variety of socio-economic, educational, and religious backgrounds, and of different races. The average group enrollment was 20 persons.

The major purpose of this experiment was to discover what the response to its materials and program would be when used by a variety of groups over a wide geographical area. The type of evaluation used was subjective. Each participant was asked for his own opinions and feelings in regard to his experiences in the course. To encourage expression of frank reactions the evaluation forms had no place for signature.

The statistical results reported here are based upon responses from 72 groups whose reports had been received by January 1955. The total membership of these groups was 1,457. Approximately 75 percent turned in the evaluation forms.

Responses of these 1,092 persons were considerably more favorable than had been anticipated: 98 percent expressed approval of the basic material; 97 percent listed one or more values the basic course had for them; 96 percent said they would recommend this material for another discussion group; 91 percent wished to take another similar course.

Comments showed a tremendous enthusiasm for the study-discussion group as a way of learning. Group members and leaders alike named as "strong points" of the program: the basic readings; the discussion; the supplementary pamphlets ix major topics; and the subgroup on.

e program has been limited to ders trained to conduct study- the Parenthood in a Free Nation plan are available or where provision can be made for training them. The materials may be purchased only by members enrolled in such groups. Despite these limitations, some 255 groups used the Project's materials during the first 18 months in which they were available. By June, this year some 250 more will have used them.

Practically all leaders and group members who participated in the nationwide experimental program agreed that persons who lead a study-discussion group in Parenthood in a Free Nation should have had not only the basic course but also a leadership training course especially designed for this program. They also agreed that only professional leaders should train leaders, whether professional or lay. The Project adopted these policies.

The question is often asked: "Is the leader of your study-discussion group a professional or a lay leader? Some persons are skeptical of all lay leadership, maintaining that a leader of a discussion group in any field must be a person professionally trained in that field. At the other extreme are those who make no distinction in the competence of the professional and the lay leader, not recognizing the rather obvious limitations of the latter. The Parent Education Project regards both professional and lay leaders as needed in parent education. Neither is a substitute for the other for they supplement one another.

Who is a "professional leader" in parent education? This question is not easily answered. The field cuts across many disciplines; it does not at present represent a standardized profession. For purposes of the Parent Education Project, a *professional* leader is a person who has professional training in the field to be studied—in child development and guidance, parent- and family-life education, or some other subject matter directly related to the content of the basic course.

The Leaders

A survey of the professional leaders who have been assigned by cooperating organizations to work in Parenthood in a Free Nation shows that they represent a wide variety of professions. Public-school representatives include superintendents, supervisors, principals, psychologists, visiting teachers, counselors, guidance directors, curriculum consultants, specialists in parent and family-life education, and classroom teachers. University representatives include teaching faculty from such departments as education, psychology, child development, and family-life education, and specialists from extension

In Chicago the public school system is sponsoring parent discussion groups which use the plan and materials developed by the University of Chicago Parent Education Project. Here a group of parents meet in a local school library.

services in parent and family-life education. Included among representatives from other community and family service agencies are social workers, mental-health specialists, and directors of religious-education programs.

Such leaders are likely to vary considerably in their knowledge of child development and guidance, parent and family-life education, and other segments of the course's content. Since parent education is not a standardized profession, it is difficult, if not impossible, to set up specific criteria to determine eligibility or competency for professional leaders in such a project. A constantly recurring question is: If a school or agency accepts a person as professionally qualified and is willing to pay him a salary for working in parent education, should a project such as Parenthood in a Free Nation automatically accept that person as a qualified professional leader in its program?

The term "lay leaders" is not new in parent education nor is it synonymous with "volunteer leaders," many of whom are former professional workers. It refers rather to discussion leaders who have not had professional training in the specialized fields involved in parent education.

Both professional and lay leaders are likely to be quite untrained and even inexperienced in the process of group discussion. They need to acquire knowledge and skills concerning the philosophy and techniques of discussion before they can become competent as leaders of either type.

When professional and lay leaders cooperate in building a program for study-discussion groups, they form a "team" in which each has his respective contributions and responsibilities. The functions of each depend somewhat upon the particular program in which he serves. Professional leaders are required for training lay leaders, for the latter need continuous orientation and guidance in dealing with the subject matter involved. They also need to understand how their roles as lay leaders differ from the role of professionals.

The functions of the professional leader go beyond his training responsibilities. He needs to be available for advice and counsel as the leaders whom he has trained turn to him for help with problems they encounter as they lead their groups. Ideally, every group should have one or more professional persons assigned to it as *consultants* and *resource persons* for specialized guidance. Unfortunately, professional leaders are not always available for this purpose. However, members of groups using the Parenthood in a Free Nation plan get some guidance from trained specialists in the basic readings and supplementary pamphlets which serve as the basis for study and discussion.

The lay leader in Parenthood in a Free Nation is not expected to be an expert; he is not supposed to "know the answers." Through his leadership training course he acquires understanding of study-discussion group purposes and methods, and he learns how to guide group discussion effectively. He also receives some basic orientation to the subjects of child development and parent-child relationships through a 12-session course. In all of his work with groups, however, the nonprofessional leader stays within the role of a *lay* leader. He is a member of the group seeking with the other members to gain increased knowledge and understanding and to learn how to find answers to his problems.

The professional leaders to whom both parent and teacher groups turn for help in child guidance are likely to be physicians, psychiatrists, psychologists, mental hygienists, educators, social workers, home economists, or specialists in child development. The demands on them are so great that they are not likely to be able to accept major responsibilities for leadership of parent discussion groups. Moreover, although such specialists are available in numbers in urban and university centers, in many other communities they are scarce or nonexistent. Any program designed to be a mass medium of education must develop and depend upon lay leaders.

A growing number of persons, both professional and nonprofessional, are convinced, too, that lay leadership of study-discussion groups has its own unique merits in a program designed to utilize the great potentialities of joint, cooperative efforts of lay and professional persons.

Pitfalls and Problems

Even the most experienced and skilled leaders will not always find smooth sailing on the active seas of lively group discussion. Almost every group encounters pitfalls and problems at some time.

The problem which group leaders report as the one they most frequently encountered is the tendency of parents to talk about their own children. A request for suggestions in the evaluations of the experimental groups brought recommendations from 98 persons for "less personal discussion." On the other hand, the only disappointment expressed to any great extent came from 227 persons who said that they had hoped to get specific answers or solutions to personal problems.

It is natural for both parents and teachers to wish for "pills and prescriptions" for dealing with children's daily behavior and personality problems, to want a specific answer to the question: "What should I do when Johnny does thus and so?" However, since every child is a unique individual one must know the specific child, as well as the circumstances under which he acts, in order to give a wise answer to such a question.

The Parenthood in a Free Nation plan is not designed to give specific and personal "answers" to participants in study-discussion courses. It is designed to help parents and teachers acquire the knowledge and understanding which will enable them to decide for themselves how to meet the common everyday problems they encounter.

Basic Information

This is not to imply that a good parent-child relationship can be established on a purely intellectual basis. Obviously, such a relationship is primarily an emotional one. However, intellectual comprehension of the parental role and a genuine understanding of children's needs can be important components in an emotionally healthy relationship.

Unusual behavior in a child calls for the advice of specialists who can make a careful study of the child and his specific difficulties. Such problems cannot properly be dealt with in any discussion group.

Even a trained leader who in his professional capacity deals with deviant behavior in children would be reluctant in a group discussion to give specific advice about a child he has not studied. Lay leaders certainly cannot be expected to have the answers to such problems and should not attempt to give them. They should, however, be able to give information about community resources to parents who need professional guidance. Even in communities where such resources are not available it is not wise to discuss complex personal problems in a group under lay leadership.

This does not mean, of course, that parents should never give examples from their own experience in a group discussion. Such examples can furnish helpful illustrations of the points discussed and can often be given without identifying the child. If the behavior described is so typical of children as to be of interest to other parents who may be encountering the same difficulties, such examples often inject vitality into the discussion.

Because many parents do need to talk out personal problems, there is a place for actual "group therapy" under the guidance of professional leaders trained for therapeutic work. However, Parenthood in a Free Nation courses are primarily *educational*. As in all good educational experiences, however, they are likely to produce a therapeutic byproduct. Many parents who have entered a course under the mistaken impression that they would obtain specific solutions to personal problems, have later said: "What I did get is so much better, for I now have the basic knowledge to help me make my own decisions."

Goals and Achievements

Any experimental program raises the question: What benefits do participants derive from the experience?

Parenthood in a Free Nation has four specific goals:

1. To increase parents' knowledge and understanding of children and of themselves, and to develop their ability to utilize these in helping their children become mature, responsible citizens of a democracy.
2. To stimulate parents to seek such knowledge and understanding continuously.
3. To help parents feel more secure in their relationships to their children, and to acquire increasing confidence in their own judgments.
4. To help parents grow in their ability to share their knowledge and experience and to learn to solve their common problems through study-discussion groups.

In the ultimate evaluation of any parent-education project the two most significant questions are:

1. To what extent do parents become more adequate, wiser, and happier through the experiences afforded by the project?
2. To what extent do children themselves actually benefit through their parents' participation in such a project?

As Nina Ridenour recently pointed out in CHILDREN ("The Critics and Parent Education," September–October 1955), ". . . up to now we have few if any real measures of effectiveness." As she says, ". . . we are nearly always obliged to rely on the combination of demand and opinion." In the Parent Education Project, objective tests have been explored a little, but thus far "demand and opinion" are the methods of evaluation employed.

Participants in the experimental groups were asked: "What did you get from this course that is of value to you?" This was presented as an "open-ended" question, but it was suggested that before answering respondents might want to review the four specific goals published in the introduction to the basic course booklet.

Of the 1,092 persons who returned evaluation forms, 97 percent named values gained from the course; many listed several. When these were classified according to the four specific goals, it was found that values related to goal 1 were mentioned 1,556 times; goal 2 was specifically mentioned 119 times; values related to goal 3 were listed 510 times; and those of goal 4 were mentioned 367 times.

Since the purpose of the course is not only to help develop good relationships between parents and children, but also to help build the kind of family life which strengthens democracy, community-wide participation is desirable. The most obvious approach to large numbers of parents is through the public schools.

Schools, however, are not the only avenues to parents. Churches, family-service agencies, mental-health societies, and many other types of community organizations often sponsor parent-education programs and many have used the plan and materials of Parenthood in a Free Nation. They may cooperate as cosponsors of a community-wide program or organize their own parent-education programs separately. Several business and industrial firms are interested in making courses available to their employees.

A rich variety of organizational patterns has developed within the Project. Most frequently sponsorship is by the local public-school system, with the parent-teacher association as cosponsor, and leadership training is done by universities and colleges. For example, the University of Denver offers leadership training for groups which function in the public schools. In Utah, the program of Parenthood in a Free Nation is being extended through the public schools by the State Department of Public Instruction.

The Future

Foundation support can be expected for a program during the period when materials and methods are being created and tested. It may continue while the program is being established on a wider basis, but a program's permanence depends upon support from local communities.

Recognizing this, the Project from the beginning has expected sponsoring organizations to assume a considerable part of the expense for the operations in their communities. It has not made grants to cooperating centers nor paid persons to organize or lead groups.

If this policy of relying on community support can be further emphasized as the program expands, all that would eventually be necessary to maintain the Project, would be a small staff to review new supplementary materials, such as pamphlets and films, to revise periodically some of the Project's publications, to prepare occasional new publications, and to give guidance and consultative service to cooperating centers. Experience thus far seems to justify the belief that ultimately a sufficiently widespread program could gain enough community support to maintain such a staff.

PROJECTS AND PROGRESS

California and Intercounty Adoptions

For the past year the California Department of Social Welfare has had a special staff working on intercounty adoptions, set up in response to the many requests for this type of service since Congress passed the Refugee Relief Act of 1953. On recommendation of the department, the Governor's office and the State Department of Finance, legislative approval was given to the employment of six additional persons in the welfare department, five of them to make studies of persons applying for foreign children and one to develop the necessary policies and coordinate the work with national agencies.

The program was launched in March 1955. Operating staff were attached to two of the independent adoption units of the department, one covering the northern portion of the State, and one the southern. Plans for referral of applicants and processing requests were worked out with the American branch of International Social Service and other national agencies and guide and informational material for department staff was developed. Orientation sessions were held in the two offices for the newly employed staff as well as for the workers in the independent adoption units.

The department accepts referrals and requests for service primarily from International Social Service, a nonsectarian voluntary agency, though it also works with the national sectarian agencies.

A major problem which arose at the time arrangements were being made with International Social Service was the requirement of the U. S. Department of State that assurances of applicants for children must be underwritten by a national agency. Since International Social Service provides many types of service other than adoption, it was in no position to assume responsibility for a child's support and to see that other plans were made for him if the adoption plans should not work out after placement, unless a local agency would guarantee funds to provide such care. On the other hand, the California Department of Social Welfare could not on its own guarantee assumption of responsibility for a child and his expenses.

This difficulty was surmounted through reference to a recent amendment to California's adoption law, which provides that if in investigating an adoption petition the department recommends that the child be removed from an "unsuitable" home the court may commit the child to the department to arrange another placement or make other plans. International Social Service accepted this provision in lieu of a guaranty and agreed to underwrite assurances.

Three types of situations are involved in the studies the department is requested to make:

1. A child is being adopted abroad by American citizens, usually military personnel stationed there, and an agency in the country involved is asking that some evaluation be made here of the family seeking an adoptive child.
2. An American family is attempting to bring in for adoption a child related to them, a child with whom they have some ties, or a child known to them in some other way.
3. An American couple is interested in adopting a foreign-born child to be selected for them by an agency abroad.

In making its studies in California of applicants for a child, the State Department of Social Welfare gives top priority to families who are seeking entrance of a child relative or one with whom they have other ties. For example, a study was made of the home of a returned GI and his German wife, who had been trying for many months to bring in the woman's child by a previous marriage. Another study was also made and the home approved, of a Negro sergeant and his wife for a Korean-Negro orphan, whom the man had found and befriended while he was with the Army in Korea.

Next in priority are requests received from International Social Service for "references studies" of California families abroad who are applying there for a child. This is done through contacts with relatives, employers, neighbors, and other persons who have known the family.

Third in order of priority are studies of applicants in California for a child to be selected by an agency abroad. Services of this type are limited according to the availability of foreign-born children and the number of applicants already approved and waiting. The completed studies are forwarded to International Social Service which selects the child from among the children known to it through information transmitted from agencies abroad.

Between March and December 1955 the department has received more than 900 inquiries and requests for service.

As of the end of October, 25 foreign children were in family homes in California who had come to this country following the department's study of the adoptive parents. Among these, 6 children had already been adopted, and 19 were under the supervision of the department awaiting completion of the adoption. Altogether 78 homes had been studied and approved. Of these, 58 homes were still available, 35 for specific children and 23 for children to be selected by an agency. During the same period, 57 studies had been made of California citizens applying to adopt children abroad.

World Health

Recommendations concerning production and use of poliomyelitis vaccines were made by a group of medical scientists from nine countries who met at Stockholm, Sweden, last November. The meeting was called by the World Health Organization to help the organization give practical guidance to nations requesting advice on establishing polio-vaccination programs. Countries represented were Norway, Sweden, South Africa, Canada, Denmark, France, Germany, United Kingdom, and the United States.

The group recommended that any country considering establishment of such a program base its decision on two factors: (1) the seriousness of its polio situation, especially with regard to the paralytic form of poliomyelitis (2) the cost and practicability of such a program in relation to the funds and facilities available and to the saving in human suffering and in the cost of hospital and social care.

As a general rule, the members recommended that countries with a high incidence of paralytic polio should plan routine vaccination at an early date; that countries with a low incidence of this dangerous form of the disease should decide to vaccinate on a large scale only after a careful review of all relevant circumstances.

Recognizing that in many countries little information is available on the prevalence and seriousness of the disease, the group urged that surveys be made to provide such information.

The group agreed that certain inoculations, particularly those that cause severe local reaction, could have a "provocative" effect that in some way increases the danger of poliomyelitis infection.

Several recommendations concerned lines of research to be followed, such as study of the "living virus" type of vaccine, which is different in principle from the "inactivated virus" of the Salk vaccine. The members also offered a number of technical comments on current safety-testing procedures.

Professional Training

A 3-year study to discover the best type of education for today's social worker has just been begun by the Council on Social Work Education. Six grants totaling more than $260,000 have been contributed to finance the work.

The study will try to answer such questions as: What is the appropriate distribution of the social-work curriculum on the graduate and undergraduate levels? What is the desirable social-science content of social-work education? How can better integration be achieved within the curriculum?

Selected issues in three areas of the current graduate-level social-work curriculum will be examined: social-work methods, including field-work practice; human growth and behavior; and the social services, especially public services and rehabilitation.

The study will try to identify those knowledges, skills and attitudes which are essential for effective functioning in the specialized areas of practice, and will also consider the question of whether new findings from other fields need to be brought into the social work curriculum.

The study will also try to determine the validity of its tentative assumption that there are two levels of social work functioning, technical and professional, and that each requires both common and distinct attitudes, skills, and knowledge. If it finds this true, it will seek to discover whether differential educational experiences can be developed for each level of functioning.

The contributors to the financing of the study are the Rockefeller Brothers Fund; the Field Foundation; the Ittleson Family Foundation; the National Tuberculosis Association; and the National Institute of Mental Health and the Office of Vocational Rehabilitation, both of the U. S. Department of Health, Education, and Welfare.

The Mentally Retarded

As a step toward formulating recommendations for a comprehensive program for the mentally retarded, Philadelphia's Commission on the Mentally Retarded recently made a study to determine how large a group would be involved. This indicated that over 50,000 children and adults in the Philadelphia area are considered mentally retarded—13,500 of them of school age and 6,500 of preschool age.

The Commission, reported to be first of this type established in any city, developed out of a child-welfare advisory board to the Department of Public Welfare, appointed by the Mayor in 1952. It consists of 24 members, representing such groups as the city departments of public health and public welfare, the public and parochial school systems, mental-health associations, a cerebral-palsy clinic, the municipal court, and the National Association for Retarded Children.

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A nursery school for mentally retarded children has recently been opened in St. Paul, Minn., by the Ambrose H. Wilder Foundation, which also operates four other nursery schools in that city—three for children of working mothers and one for blind children. The new program aims to care for, and possibly train, children between the ages of 3 and 8 having I. Q.'s below 50; and to help mothers take better care of their other children by assuming the retarded child's care during the day. Parents will be counseled by two staff social workers.

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Michigan's State Mental Health Association has received a $75,000 grant from the McGregor Fund to begin a 3-year pilot project in mental health. The program aims at helping schools make their environment conducive to the development of better mental health in the pupils.

Poison Centers

By the end of 1955 poison-control centers were operating in 14 cities and were being developed in many others. The centers, which have been established largely through the efforts of the American Academy of Pediatrics, work along several lines to prevent deaths from poisoning:

In response to telephoned requests from doctors and hospital emergency rooms, they give advice on appropriate treatment for a child or adult who has swallowed some poisonous substance. They also give first-aid advice to parents. Most of them offer these services 24 hours a day.

They collect data on poisoning cases to help in prevention programs.

Some centers issue bulletins warning of new poison hazards and recommending treatment methods recently developed. Some conduct programs to teach parents and others how to prevent poisoning and how to give first aid.

The core around which a program operates may be a health department, a hospital, a medical college, a local medical society, or a combination of some of these. Various agencies participate, the number joining with a single center ranging from 1 to more than 100. Cooperating groups include such agencies as visiting-nurse associations, safety councils, medical and pediatrics societies, local branches of the American Academy of Pediatrics, hospitals, State and local health departments, and coroners' or medical examiners' offices. The pesticide department of the agricultural school of a State university participates in one program; and an industrial-laboratory facility in another.

The first poison-control center was established in 1954 in Chicago. (See "A New Life-Saving Service Is Launched," by Edward Press, CHILDREN, May–June 1954.) Since then the number has grown to include: Boston; Dallas, Tex.; Durham, N. C.; Grand Rapids, Mich.; Harrisburg, Pa.; Indianapolis, Ind.; Louisville, Ky.; New Bedford, Mass.; New York; Phoenix, Ariz.; Springfield, Ill.; Newark, N. J.; and Washington, D. C.

Currently the American Public Health Association in conjunction with several other national agencies is exploring the feasibility of a national clearinghouse for poison-control programs.

Juvenile Delinquency

Most local community welfare councils are planning activities directly focused on the problem of juvenile delinquency, according to answers to a questionnaire sent out recently by a joint committee of the Community Chests and Councils of America and the National Social Welfare Assembly. Only a little more than a third of the 107 councils answering, however, had special committees dealing with the problem.

A number of replies reported a need for more information and consultation from national sources, particularly in regard to new methods that have proved successful in dealing with delinquency in other communities.

About half the reporting councils expressed a desire for a greater two-way flow of information between local and national agencies. Many emphasized the importance of relating information to the needs of small communities. While councils in large communities indicated that they were well informed, a number of small-community councils stated that they knew too little about national developments.

A few councils expressed need for more national coordination and planning, especially between governmental and voluntary services, and for bringing law-enforcement agencies, service clubs, and other groups into the planning program.

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The high incidence of American Indian children committed to the South Dakota State training school is directly traceable to unstable home conditions and to lack of child-welfare facilities, according to a report of the Bureau of Indian Affairs, Department of the Interior. The report was based on records of all the Indian children committed to the school in 1953 and 1954.

While Indians make up less than 4 percent of the State's population, in these 2 years 60 Indians attended the school which has an average total enrollment of 125 children. Of the Indian children 41 were boys and 19 were girls. Most of them came from economically poor homes.

Most of the offenses were of types regarded by the investigators as growing out of family instability or neglect, bad associations, uncurbed mischievousness, or emotional difficulties. They included burglary, larceny, forgery, drunkenness, assault, immoral conduct, truancy, and running away from home or school.

Only one child had been committed for a first offense. The others had all been before courts earlier. In a substantial number of cases the previous court experience involved offenses against the child, such as desertion, neglect, or nonsupport.

The report recommends that measures be taken to prevent situations in Indian and white families that lead to commitment.

Unmarried Mothers

Several recommendations arising from a study in Hawaii of children born out of wedlock and their mothers have been made by the Territorial Commission on Children and Youth in a recent report to the Governor.

The study committee found that although medical facilities are available to unmarried mothers in the Territory many of them do not apply for medical care early in pregnancy and do not receive as thorough care for themselves and their children as do married mothers. One factor which deters them from seeking such care, the committee maintained, is fear of being pressured into taking steps to establish paternity. Many illegitimate pregnancies in the islands, it reported, are the results of casual relationships between island girls and members of the armed forces.

Nearly half of the approximately 700 babies born out of wedlock in Hawaii each year are released for adoption, according to the committee. Among its recommendations are: further study of the problems of unmarried mothers living in common-law relationships, of the incidence of repeated illegitimate pregnancies, and of policies of the armed forces in regard to unmarried mothers of children of military personnel, especially in relation to medical care and economic help; better public education to combat prejudice against unmarried mothers and their children; a review by public-health authorities of policies and practices which may deter indigent girls from receiving medical care; a Territorial conference on illegitimacy bringing together representatives of educational, health, social-work, legal, and religious groups.

Changes in the Territorial law suggested by the committee include, among others, provisions to permit privacy in proceedings for establishing paternity; to require the father to support the child for a longer time than the present law specifies; and to entitle a child who has been legitimated to the full legal rights of a child born in wedlock.

Joint Conference

Some 200 representatives of the three coordinating organizations for agencies dealing with children and youth met in Washington early last December to look at present and future programs. The three groups sponsoring the meeting were: The National Advisory Council of State and Local Action for Children and Youth, composed of 51 State and Territorial Committees on Children and Youth; the Council of National Organizations for Children and Youth, representing 464 national voluntary organizations; and the Federal Interdepartmental Committee on Children and Youth, representing 28 Government agencies.

The agencies belonging to these three organizations played a leading role in the Midcentury White House Conference on Children and Youth. The participants of this 2-day meeting at the mid-decade point reviewed progress made on the recommendations of that conference, and looked ahead at program needs of the future both from an economic and a social standpoint. Featured speakers predicted general needs in the fields of health, welfare, and education, and representatives from State committees reported on activities underway to meet current needs.

Among the projects reported as being sponsored by State committees were:

A 2-year study of children in detention and shelter care in California.

A Town Meeting program in California through which people get together locally to express their ideas and plan programs for children and youth.

A survey of emotionally disturbed and mentally retarded children in four counties in Mississippi which has led to organization of mental-health groups and of classes for exceptional children.

The establishment in Vermont of a number of schools for mentally retarded children, a summer camp for the mentally retarded, and more child-guidance clinics.

A 2-year privately financed project in North Carolina to combat infant mortality, involving preparation and wide distribution of a publication for mothers.

The enactment, in Michigan, after a 5-year effort by the Youth Commission to point out the need for more and better foster family care for children, of legislation under which the State shares with the counties the cost of foster care.

Representatives of several State committees told of increasing interest in dealing more effectively with juvenile delinquency. The State of Washington, it was reported, has created a section on community services in its Department of Institutions. This section approaches the delinquency problem through 18 child-guidance centers scattered throughout the State; three juvenile-control officers who offer help to local law-enforcement authorities, including training for juvenile-police officers; and two community consultants.

Here and There

In October 1955 the number of children served lunches with milk under the National School Lunch Program had climbed to 9,400,000—a gain of 10 percent over the average of 8,500,000 in October 1954, according to the U. S. Department of Agriculture.

For the separate program known as the Special School Milk Program, now in its second year of operation, 62,000 schools had been approved by mid-December 1955, 48 percent more than during the peak month in 1954.

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As a step toward preventing confusion in the identities of new-born infants and toward deterring attempts to circumvent adoption laws through fraudulent birth registration, California's State legislature in 1955 enacted a law requiring that each newborn baby's footprints be imprinted on the back of his original birth certificate, along with his mother's fingerprints.

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The newly formed National Association of Social Workers early in January brought out the first issue of a quarterly, *Social Work*. Besides presenting technical and theoretical articles on various phases of social work, the journal includes special sections on groupwork, medical social work, psychiatric social work, and school social work.

Guides and Reports

TEACHING CHILDREN WHO MOVE WITH THE CROPS; report and recommendations of the Fresno County Project, the educational program for migrant children. Published by Walter D. Martin, Fresno County Superintendent of Schools, Fresno, Calif. 1955. 95 pp. Free to persons in work with migrant children.

Addressed to teachers and other school workers and to citizens concerned with providing opportunities for such children in the public schools, this pamphlet points to the educational needs of children who are continually on the move and suggests ways of fulfilling them.

CONGENITAL MALFORMATIONS AND BIRTH INJURIES; a handbook on nursing. Jessie Stevenson West. Association for the Aid of Crippled Children, 345 East 46th Street, New York 17, N. Y. 178 pp. $1.

Successor to a 1943 booklet by the same author, this handbook emphasizes the present-day broad conception of treatment—total care aimed at habilitation of the child. The conditions discussed include several for which children formerly received little more than hygienic or custodial care.

REACHING ADOLESCENTS THROUGH A COURT CLINIC. New York City Youth Board, 500 Park Avenue, New York 22, N. Y. Youth Board Monograph No. 3. 1955. 62 pp. 50 cents.

Describes an experimental clinic at which boys and girls brought before a court for delinquency are given psychiatric treatment.

THE EVOLVING CONCEPT OF REHABILITATION. TEAMWORK: PHILOSOPHY AND PRINCIPLES. Monographs I and II in the series, Social Work Practice in Medical Care and Rehabilitation Settings. The American Association of Medical Social Workers (now Medical Social Work Section, National Association of Social Workers), 1700 I Street NW, Washington 6, D. C. 35 cents each.

This material was presented at an institute held at the Pennsylvania College for Women in June 1955 under a grant from the Office of Vocational Rehabilitation, U. S. Department of Health, Education, and Welfare. The purpose of the institute was to train medical social workers to assume leadership roles in workshops.

DEVELOPMENTAL CONCORDANCE AND DISCORDANCE DURING PUBERTY AND EARLY ADOLESCENCE. Douglas M. More. Monographs of the Society for Research in Child Development. Champaign, Ill. 1955. 128 pp. $3.

Examines developmental data on 33 adolescents—17 girls and 16 boys—recorded in an effort to discover relations among physical, social, and emotional characteristics.

PROMISE FOR YOUTH. I. Exploring psychiatric research in juvenile delinquency. Welfare and Health Council of New York City, 44 East 23d Street, New York 10, N. Y. 1955. 61 pp. $1.

The report of a conference on this subject, held in March 1955 at Princeton, N. J., briefly summarized in CHILDREN, September-October 1955. Reports II and III will be on future conferences on delinquency research in relation to other disciplines.

IN THE JOURNALS

Homemaker Service

Nora Phillips Johnson, director of the Children's Aid Society, New York, points out in the January 1956 issue of *Child Welfare*, that better understanding of child nature and of family life has led social and health agencies to a broader use of homemaker service to keep families together. Other circumstances besides illness of the mother are now recognized as factors indicating the need for a homemaker, says the author. As examples she cites times when a mother is caring for a convalescent or handicapped child and when an employed mother is supporting a fatherless family with the help of Aid to Dependent Children. Agencies that place children in foster-family homes, those providing protective care for dependent or neglected children, health agencies, and day-care centers are listed as groups that now recognize the need for homemaker service in keeping intact the families they are serving.

Some of the child-welfare concepts leading to this broader use of homemaker service, according to the author, involve: the importance of preserving the child's identity by not removing him from his known world; the importance of the mother and of the father in the child's life; and the need for early help in preventing family breakdown.

Fluoride Study

Further evidence pointing to the safety of water fluoridation as a public-health measure to prevent dental decay is presented in a study made in New York State, which is reported in the *Journal of the American Medical Association*, January 7, 1956, by Edward R. Schlesinger, David E. Overton, and Helen C. Chase. The physical status of 100 boys 12 years of age in Newburgh, where the water has been fluoridated for about 8 years, was compared with the status of 100 boys of the same age in Kingston, where the water is deficient in fluoride.

Careful pediatric examinations were given, heights and weights were measured, blood-cell counts taken, and special ophthalmologic and otologic examinations made. In order to detect possible effects of fluoride on the kidneys, urine was analyzed by refined methods, with special attention given to the quantitative excretion of albumin, red blood cells, and casts. The investigators found no significant differences in the physical status of the two groups and such differences as were found favored the boys who had been exposed to fluoride. This study is part of a 10-year investigation.

Predictive Tests

Dr. Nancy Bayley provides, in the December 1955 *American Psychologist*, a summary of her longitudinal studies, showing that scores on infant tests bear no relation to I. Q.'s in the school-age period or at maturity.

These studies, she reports, confirm the view that, from age 6 on, the I. Q. is fairly constant and is thus a useful, if limited, predictor of adult mental ability.

From her evaluation of the attempts being made to improve the predictive value of infant tests, Dr. Bayley concludes that these efforts "give little hope of ever being able to measure a stable and predictable intellectual factor in the very young."

She also summarizes her recent report on the correlations between parents' educational status and their children's scores on tests given at successive ages. She has found that these correlations are negative when the infant is between 4 and 12 months of age, but thereafter increase rapidly until the child is about 4, when a fairly high correlation is reached. From 4 to 18 they continue to rise, but slowly.

Long-Term Illness

In *Nursing Outlook*, December 1955, a doctor and a nurse point out some of the needs beyond medical, surgical, or hospital care of a child with a long-term illness. Dr. Herbert Kobes, director of the University of Illinois Division of Services for Crippled Children, presents an example of comprehensive care given to a child with rheumatic heart disease. Mary Dephas Ford, assistant supervisor of nursing services in the same agency, explains the part taken by a public-health nurse in the care of the same child. One of the nurse's most important functions, according to Miss Ford, is to help anxious fathers and mothers understand what is being done for their child and to help them take part in restoring the child to health.

A Hospital Playroom

Hospitals are becoming more aware of the importance of establishing a play space as part of the pediatric service and of staffing it with understanding workers, says Etta M. Gould, in *Nursing World*, December 1955. The author, who is supervisor of the pediatric playroom in New York City's Bellevue Hospital, shows how her playroom works to give children the comfort and reassurance they need.

Psychotherapy Needed

A transcription of a discussion of the preventive use of psychotherapy in childhood, presented by a panel of two child psychiatrists and two pediatricians at a meeting of the New York Academy of Medicine, appears in the January 1956 *Bulletin* of the Academy. At this meeting Dr. Clement B. P. Cobb, pediatrician, since deceased, told of a study of 100 children between the ages of 2 and 17 seen in his private practice, which indicated that nearly half seemed to need psychotherapy. An "enormous" incidence of disturbed children in three day-care centers was reported by Dr. Marianne Kris, a psychiatrist, who noted that all these children's mothers were either employed or sick.

Dr. Milton I. Levine, a pediatrician, reminded the group that while some neurotic symptoms in children are deep-seated, others are transitory. Consultation centers at which attempts can be made to distinguish between behavior that needs immediate psychotherapy and that which probably can be taken care of through a few understanding interviews were advocated by Dr. Marian C. Putnam, a psychiatrist, who also suggested that well-baby clinics and nursery schools might develop this function further.

Dr. Lawrence S. Kubie, acting as moderator, noted that the panel members agreed that serious attention should be paid to a child's emotional disturbances and that they should not be ignored in the hope that he would outgrow them.

BOOK NOTES

YOUTH AND THE LAW; handbook on laws affecting youth. Frederick J. Ludwig. The Foundation Press, Brooklyn, N. Y. 1955. 386 pp. $5.50.

Prepared under the sponsorship of the Youth Counsel Bureau, an independent unofficial agency operating out of the office of the District Attorney of New York County, this handbook brings together many facets of law especially applicable to children and young people. With emphasis on the laws of New York State, the book deals with: (1) responsibility of young offenders; (2) the courts and judicial procedure; (3) treatment of juvenile offenders; and (4) protection of young persons.

In an epilogue the author offers suggestions for improving laws and procedures intended to prevent offenses by young persons. Provisions of the various State laws concerning criminal responsibility of minors and responsibility of parents and others for juvenile delinquency are presented in tabular form.

DELINQUENT BOYS; the culture of the gang. Albert K. Cohen. The Free Press, Glencoe, Ill. 1955. 202 pp. $3.50.

The author, assistant professor of sociology in Indiana University, recommends that research on juvenile delinquency start, not with known delinquents, but with representative samples of the juvenile population drawn without regard to their known or probable histories—these children would later be differentiated as delinquent and nondelinquent. Secondly, he urges that research bring to light fuller and more detailed data on delinquent actions. He also suggests continued and expanded research on delinquent groups rather than on individuals.

In support of these suggestions, he maintains that delinquency seldom consists of individual activities; that usually delinquent acts are joint ones—boys doing things together. These acts, he says, are governed by a set of common understandings, sentiments, and loyalties, which form a delinquent subculture. Children belonging to this subculture are ill equipped to meet society's value system but their delinquent subculture provides criteria for achieving status that they can and do meet.

THE PSYCHOANALYTIC STUDY OF THE CHILD, Vol. X. Ruth S. Eissler and others. International Universities Press, New York. 1955. 394 pp. $7.50.

Nineteen papers are presented in this volume, grouped in four sections: "Problems of Ego Development," "Genetic Problems," "Problems of Psychosexual Development," and "Clinical Presentations."

THE PEDIATRIC YEARS; a guide in pediatrics for workers in health, education, and welfare. Louis Spekter, M. D. Charles C Thomas, Springfield, Ill. 1955. 734 pp. $12.50.

The author of this book describes it as "a technical volume designed specifically for the nonmedical members of the team who work with children." Among these he lists: social workers, physical and occupational therapists, nutritionists and dietitians, nurses, dentists, psychologists, staffs of child-care centers and nursery schools, teachers of the handicapped, health educators, camp directors, and rehabilitation counselors. Beginning with the fetal period, the book discusses various phases of the health of children up to 16 years of age. It also discusses the functions of health workers and of health services, voluntary and official, and suggests health standards for various types of child care.

BEHAVIOR AND DEVELOPMENT IN CHILDHOOD. Alfred L. Baldwin. The Dryden Press, New York. 1955. 619 pp. $6.25.

Since each child is unique and has a unique history, says the author of this textbook in child psychology, it is essential to have an adequate theoretical system as a basis for predictions in real situations. Offering such a system, he devotes part 1 of the book to an explanation of how children behave and how their behavior differs from that of adults, and part 2 to a discussion of personality change.

EMOTIONAL PROBLEMS OF EARLY CHILDHOOD. Edited by Gerald Caplan. Basic Books, New York. 1955. 544 pp. $7.50.

Based on papers presented at the International Institute of Child Psychiatry, held at Toronto in 1954, this book is divided into three sections: "Preventive Aspects of Child Psychiatry"; "The Relation of Physical and Emotional Factors, and Problems of Hospitalization"; and "Problems of Psychosis in Early Childhood." Each section includes: a group of case histories, each history followed by discussion; several accounts of current research projects; and an interpretive essay. The contributors include experts from the United States and four other countries—Canada, France, Israel, and Norway.

COMMUNITY PROGRAMS FOR MENTAL HEALTH; theory, practice, evaluation. Edited by Ruth Kotinsky and Helen L. Witmer. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Mass. 1955. 362 pp. $5.

The papers in this book, according to the editors, "are to be regarded as depicting the current state of mental-health promotion work in the United States, with suggestions for directions to be taken if the aim of the work is to be clarified and fulfilled."

In discussing the theoretical assumptions of the mental-health movement, in Part I, Sol W. Ginsburg advocates clarification of ideas on training mental hygienists and the strengthening of their efforts through study, research, and self-criticism.

In Part II, Edith Miller Tufts explores difficulties in defining the mental-health field; H. E. Chamberlain and Elizabeth deSchweinitz describes nine programs—public and private—for promoting mental health; and Barbara Biber analyzes three school mental-health projects—on education for citizenship, on intergroup education, and on teacher education.

Problems in evaluation of mental health programs are considered by Louisa P. Howe in Part III. Marie Jahoda, also in this section, examines the impact of community influences on the mental health of the individual.

In an appendix Robert H. Holt comments on the issues involved in each step of making a sample survey to evaluate a mental-health program.

THE NURSERY SCHOOL AND CHILD CARE CENTER; a parents' and teachers' guide. Clark E. Moustakas and Minnie Perrin Berson. Foreword by Pauline Park Wilson Knapp. Whiteside, Inc., and William Morrow & Co., New York. 1955. 222 pp. $3.50.

On the basis of information collected a few years ago from 835 nursery schools and child-care centers, this book describes 10 types of nursery school and 3 types of child-care centers. Besides discussing the philosophy, purpose, and practices of each type the authors present statistical material including data on number of children enrolled, ratio of adults to children, length of daily session, fees paid by parents, and qualifications of staff. Twenty-one States, according to the authors, have no laws to protect children in nursery schools or in child-care centers. "Where laws do exist," they add, "they are often vague and unspecific, and enforcement is weak."

ADOPTION—AND AFTER. Louise Raymond. Foreword by Sidonie M. Gruenberg. Harper & Bros., New York. 1955. 238 pp. $3.

Couples thinking about adoption should carefully scrutinize their reasons and attempt to weigh fairly their own abilities to bring up a child, says the author of this guide. She then takes up what they may expect of the child, what part the adoption agency will play, the waiting period, the legalization of the adoption. The main part of the book is devoted to the time after the child becomes a member of the family. Telling the child he is adopted, adjusting to change as he grows older, helping him to face death or divorce in the family are a few of the many situations on which the author offers advice.

THE CARE AND FEEDING OF TWINS. Phyllis Graham. Preface by Arthur H. Parmelee, Jr., M. D. Harper & Bros., New York. 1955. 242 pp. $3.

Without attempting to deal with the usual problems of infant care, the author of this book, who is the mother of twins, concentrates on the special problems of bringing up two babies at once.

Her suggestions, she says, "may not be the best solutions to the problems involved"—feeding, bathing, clothing, laundry, and so forth—but she is offering them "in the hope of clarifying the problems. . . ."

INTERNATIONAL PUBLICATIONS

EXPERT COMMITTEE ON HEALTH EDUCATION OF THE PUBLIC. First Report. Technical Report Series No. 89. World Health Organization, Palais des Nations, Geneva, Switzerland. For sale by Columbia University Press, International Documents Service, 2960 Broadway, New York 27, N. Y. 1954. 41 pp. 25 cents.

Defines the objectives and scope of health education; outlines the way people learn; explains the role of the health educator; states broad principles of program planning, evaluation, and organization; describes the development and use of methods and media, and the training needed by health-education workers, both professional and voluntary.

SYSTEMS OF SOCIAL SECURITY: UNITED STATES. International Labour Office, Geneva, Switzerland. 1954. 106 pp. 75 cents.

Second in a series on governmental social-security programs, this report was prepared by the U. S. Department of Health, Education, and Welfare. It describes the programs as of the end of calendar year 1952 and summarizes 1954 amendments to the legislation providing for them. The first report described programs in New Zealand.

THE POLICE AND THE MENTAL HEALTH OF CHILDREN; a study published with the assistance of UNESCO. Foreword by Dr. Luther H. Evans, Director General of UNESCO. International Federation of Senior Police Officers, 11, rue des Saussaies, Paris 8^e, France. 1955. 35 cents, postpaid. UNESCO book coupons accepted.

This report is the work of a group of experts representing mainly police work, social science, psychology, psychiatry, and education, convened at Paris May 30–June 3, 1954, by the International Federation of Senior Police Officers.

Protection of a child's mental health by the police, according to the report, implies not only fulfilling the traditional police duty of removing seriously adverse influences from the child's environment, but also playing a new role in helping to foster the fullest development of the young personality. The report notes factors that threaten such development, suggests methods of police action in dealing with children, and discusses the selection and training of personnel for such work.

YEARBOOK OF YOUTH ORGANIZATIONS. Vol. 1, Europe. Unesco Youth Institute, Germeringerstrasse 30, Gauting/Munchen, Germany. 1954. App. 400 looseleaf pages. $6.50.

Presents brief information in English and French on organizations in more than 30 European countries. All but about 100 are national in scope. More than 60 are international; 7 are pan-European; 5 are regional, within Europe; and 38 are exiles' groups. The looseleaf form is used to permit address and other changes.

CATALOGUES OF SHORT FILMS AND FILMSTRIPS; selected list. United Nations Educational, Scientific, and Cultural Organization, Department of Mass Communication, Clearing House. No. 14. 1955. 25 pp. 50 cents from Unesco Publications Service, 475 Fifth Avenue, New York 17, N. Y.

Offers a guide to sources of information on availability of films and filmstrips in many countries.

READERS' EXCHANGE

RABINOWITZ and EDWARDS: ***Plodders needed***

Clara Rabinowitz and Olivia Edwards have applied themselves with patience and dedication to the task of helping children coming from backgrounds of gross deprivation. (*Socially Deprived Children:* "I. Therapeutic Work," by Clara Rabinowitz, and "II. Helping Their Parents," by Olivia Edwards, CHILDREN, January–February 1956.) Working with such children and their families has so often ended in disillusion and frustration that success must be measured against modest expectations. Any appreciable degree of movement, therefore, becomes the more impressive.

But patience and dedication are obviously not enough, since these have been the chief virtues of many others who have tried and failed. The reports from the Northside Center for Child Development in New York make it clear that a large measure of insight, imagination, flexibility, and professional skill are also essential, and that a combination of all of these presents possibilities for substantial results. Such a rare combination of talents, of course, bears a high expectancy for success in any venture, thus raising a question as to whether such a project is an appropriate place to invest them.

The question answers itself in the fact of the human wastage and the drain on community resources represented by the "hard core" of problem families.

These are not cases of simple poverty. The present-day network of income-maintenance programs, regardless of gaps and inadequacies, means that situations of gross deprivation are more likely than ever to be complicated by psychological disorders. If the Northside Center can point the way to effective techniques for dealing with these problems, its findings deserve wide application.

The difficulty remains, however, that there are too few people like Miss Rabinowitz and Mrs. Edwards. There is not only the problem of the unmotivated client, but also of the unmotivated worker. Perhaps progress in this field could be greater if more persons with talent and professional sophistication could find satisfaction in the plodding pace and the drabness which are the daily fare in working with the deprived. By comparison again, this perspective magnifies the contribution which these two people are making.

Harold Hagen
Child Welfare Consultant, American Public Welfare Association

PATTERSON: ***A doctor's defense***

Mrs. Patterson's observations are worth serious attention. ("Some Pointers for Professionals," by Letha L. Patterson, CHILDREN, January–February 1956.) They correctly emphasize the need for honesty without condescension in our approach to the parents of retarded children, remind us of the importance of imparting full and accurate information on techniques and resources in dealing with their problems, and condemn the kind of psychiatric gobbledygook that makes harassed parents feel responsible for the handicap of their child.

It may be said in defense of us doctors, psychologists, and social workers that we often do not know enough to be as informative as we ought to be; it takes a little courage to confess our ignorance to parents. We can of course make a big and important contribution to an appraisal of the child's capacities and deficits and can initiate or direct the rehabilitation process along sound lines. But we usually have to surmise and do not exactly know the nature or cause of the brain deficiency.

Yet it is important to share our ignorance as well as our knowledge with the parents. We can almost always safely assure them that the child will continue to learn and to develop, however slowly, and that the future outcome seldom can be accurately predicted. Even techniques of management need a certain permissive range of trial and error stretched over a period of time. As long as our professionals get so little special training and experience in this field, and as long as scientific knowledge lags behind, we would do well to share our knowledge and observations with the parents and together form our conclusions. A certain amount of frank ignorance can prove a real spur to work and study.

I would advise parents to rely a great deal on their own observations of their child, and above all to recognize that the handicapped brain almost invariably retains its learning capacity, however slow and peculiar the learning process may be. What parents need most of all are adequate community resources for special training of their children and later vocational placement. Parents should be especially cautious about accepting judgments not based upon a working knowledge of their own child or similar children. This is one area of knowledge in which the gap between theory and daily practice can become dangerously wide.

Joseph Wortis, M. D.
Director, Division of Pediatric Psychiatry, The Jewish Hospital of Brooklyn, New York

WRIEDEN: ***Another method***

As an agency offering both maternity-home and foster-home care to unmarried mothers, we welcomed Jane Wrieden's recent article ("The Meaning of the Maternity Home," by Jane E. Wrieden. CHILDREN, January–February 1956). We have learned much from our experience in operating a maternity home which is helpful in conducting our foster-home program, and have been seeking to fill many of the areas of need which Brigadier Wrieden has so clearly defined.

Because of the heavy volume of young teen-agers needing care and the limited capacity of our maternity home, our agency cares for most of the very young girls in foster homes which offer them a warm family experience.

We realize, however, the need of these girls for companionship, for the comfort and value of knowing others with similar problems, for group discussion and for constructive and pleasant use of leisure time and have experimented in ways of meeting these needs. Our experience has convinced us of the greater value of foster homes which can accept two or three girls. Presently only one of our 12 homes cares for only one girl, and most can care for three. This plan helps to combat the loneliness of teen-agers who are cut off from other normal teen-age companionship.

A year ago we inaugurated group meetings for the girls in foster homes, held every 2 weeks under the direction of a caseworker. Our goals for the group have been twofold: 1) to offer opportunity for companionship and group discussion and 2) to stimulate interest in sewing and crafts. This year because of the contrast between recreational opportunities in the maternity home and the uneven abilities of foster parents to stimulate and teach, our emphasis has been on sewing and crafts.

We have planned this not only to provide pleasure and a focus at the club meetings but also, and more important, with the idea of promoting a carryover of activity in the foster homes. At the same time we are discussing the recreational needs of the girls in regular meetings planned for foster mothers.

We feel certain that the closer relationship achieved by the girls to the agency in these meetings not only helps the work of the foster mother and caseworker but provides some of the feelings of security and acceptance which, as Jane Wrieden states, prove so therapeutic.

Ruth Butcher
Executive Director, Inwood House, New York City

FILMS ON CHILD LIFE

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

A FAMILY AFFAIR. 31 minutes, sound, black and white, purchase.

Shows a professionally trained caseworker helping the father and mother of two rebellious teen-agers to understand themselves better and thus avoid a family break-up.

Audience: General public; also useful for recruiting social workers.

Produced by: Affiliated Film Producers for Mental Health Film Board and the Family Service Association of America.

Distributed by: International Film Bureau, 57 East Jackson Boulevard, Chicago 4, Ill.; 20 West 55th Street, New York 19, N. Y.

CHILDHOOD RIVALRY IN BALI AND NEW GUINEA. 10 minutes, sound, black and white, purchase or rent.

Presents scenes in which two cultures are contrasted in their treatment of young children. In Bali sequences the mother deliberately foments jealousy in her child by paying attention to another baby; the New Guinea mother, on the other hand, treats the child tenderly and avoids actions that may lead to jealousy.

Audience: Advanced students of child development.

Produced by: Gregory Bateson and Margaret Mead as part of the series, Character Formation in Different Cultures.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

YOU'LL NEVER WALK ALONE. 27 minutes, sound, color, purchase or rent.

Presents a story of summer camping for crippled children. Shows various types of direct services available before the child goes to camp and while he is there.

Audience: Any civic group working for children.

Produced by: West Virginia Society for Crippled Children and Adults.

Distributed by: National Society for Crippled Children and Adults, 13 South La Salle Street, Chicago 3, Ill.

DANGER LINE. 18 minutes, sound, black and white, loan.

Demonstrates how correct walking habits improve children's posture and health and emphasizes the importance of replacing shoes often during a time of rapid growth.

Audience: Parents; children.

Produced by: Melville Shoe Corporation.

Distributed by: Institute of Visual Training, 40 East 49th Street, New York 17, N. Y.

THE SOCIAL WORKER. 20 minutes, sound, black and white, purchase or loan.

Illustrates the process through which a social worker helps families—in this case a husband and wife who were in danger of losing the foster child who had been in their home for 9 years.

Audience: Potential recruits for the social-work field; general public.

Produced by: Bill Hodapp for the New York School of Social Work.

Distributed by: National Broadcasting Co., 30 Rockefeller Plaza, New York 20, N. Y. (purchase); New York School of Social Work (loan for noncommercial use).

A BALINESE FAMILY. 20 minutes, sound, black and white, purchase or rent.

Shows how a father and mother in Bali treat their three youngest children—the smallest, or "lap baby"; the next older, who clings to the parents' knees; and the oldest of the three, who with difficulty takes care of the lap baby.

Audience: Advanced students of child development.

Produced by: Gregory Bateson and Margaret Mead as part of the series, Character Formation in Different Cultures.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

PROGRAM FOR HANDICAPPED CHILDREN. 22 minutes, sound, black and white, purchase or rent.

Reproduces a day in the life of a handicapped student in one of the special schools in the Newark (N. J.) public-school system.

Audience: Parents of handicapped children; general public.

Produced by: Department of Special Education, Newark Public Schools, in cooperation with the Department of Libraries and Audio-Visual Education.

Distributed by: Newark Board of Education, Department of Special Education, 31 Green Street, Newark 2, N. J.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

PROTECTING CHILDREN IN ADOPTION; report of a conference held in Washington June 27 and 28, 1955. 43 pp. 20 cents.

The conference reported in this publication brought together representatives of various professions concerned with adoptions—medicine, law, nursing, social work, hospital administration, and pharmacy. Their discussions stressed: (1) that measures protecting a child in adoption also protect his natural parents and his adoptive parents; (2) that persons in a position to give advice concerning adoption need to know what community resources are available to protect all concerned; (3) that unmarried mothers' needs for medical care, maintenance, and help with emotional stress should be met promptly; (4) that every mother who relinquishes her child for adoption, every child so adopted, every couple who adopts a child needs medical, legal, and social service.

SERVICES FOR CRIPPLED CHILDREN. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder No. 38. Revised 1955. 28 pp. 15 cents.

Brings up to date information on the title and location of State crippled children's agencies and lists amounts granted to each for fiscal year 1956.

THE CHILD WITH RHEUMATIC FEVER. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder No. 42. 1955. 13 pp. 10 cents.

Lists, for parents, the physical signs that may point to an attack of rheumatic fever, describes the prevention value of early treatment, and shows what medication can do to ward off recurrences.

A STUDY OF SELECTED HOME CARE PROGRAMS; a joint project of the Public Health Service and the Commission on Chronic Illness. Department of Health, Education, and Welfare, Public Health Service. Public Health Monograph No. 447. 1955. 127 pp. 65 cents.

Home care, as defined in this study, is part of a total medical-care plan, coordinated through one administrative agency or institution. Eleven programs are described—in Alameda County, Calif.; Cleveland; Boston; Chicago; Seattle, Wash.; New York; Philadelphia; Richmond, Va.; and Burlington, Vt.

HEALTH SERVICES AND JUVENILE DELINQUENCY; a report on a conference on the role of health services in preventing dissocial behavior. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. No. 353. 1955. 54 pp. 25 cents.

Recognizing that the health worker who does not specialize in mental health may nevertheless contribute significantly to its preservation and to the healthy development of children's personalities, the Children's Bureau and the Special Juvenile Delinquency Project called together the group whose meeting, May 19–21, 1955, is reported in this publication.

It describes in considerable detail the suggestions of the conferees concerning the parts in combating delinquency that can be played by physicians in private practice, general or specialized; the staff of public-health departments: school health workers, public-health nurses; medical social workers; nutritionists; and persons in related fields.

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Care of Hospitalized Children

Home Nursing in Britain

The Consistency of Culture

Hospitals for Mentally Retarded

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◀

A volunteer "substitute mother," one of several at New York City's Bellevue Hospital, provides cuddling and companionship for a lonely, sick child, whose mother cannot visit him frequently. There, as in many hospitals and communities in this country and in England (see pp. 83–94) increasing concern over what hospitalization does to children emotionally has produced new programs and procedures devised to lessen the danger of trauma for sick children.

Dr. Henry Work was associate professor of pediatrics and psychiatry at the University of Louisville Medical School before his recent move to California. A graduate of the Harvard Medical School, he received pediatric training at the Boston and Buffalo children's hospitals. After serving in Europe with the army, he trained in psychiatry at the Cornell Medical School. He has also been psychiatric consultant on the Children's Bureau staff.

Among the many books published by Len Chaloner, British journalist and author who specializes in social and health subjects, "Questions Children Ask" published in London in 1952, received considerable notice in this country. Besides writing about them, Mrs. Chaloner has worked with many children in club groups and play centers.

With a medical degree from the University of Budapest, Dr. George Tarjan practiced medicine in his native Hungary before coming to this country in 1939. Subsequently he had an internship and a hospital residency in the Middle West and was on the staff of State hospitals in Utah and Illinois. During the war he served as chief of psychiatric services at army installations in the Southwest Pacific. In his present position since 1949, he is also on the faculty of the UCLA Medical School.

Among her many activities in Los Angeles civic affairs, Mrs. Jackson Edwards has for the past 3 years included continuous participation in the program for foster home interpretation she describes herein. She began her association with the Welfare Planning Council, Los Angeles Region, as a Junior League volunteer in the Council's Volunteer Bureau, helping to recruit and place volunteers.

A graduate of the School of Social Work, University of Denver, Nancy Jaggard Swank has been in her present position since 1947. Previously she served as group worker in the YWCA's in Denver, El Paso, and Kansas City. Currently an active participant both locally and nationally in the group work section of the National Association of Social Workers, she was also active in the American Association of Group Workers, its predecessor.

Anthropologist Dorothy D. Lee has had personal as well as educational experience in the differences among cultures. Born in Turkey of Greek parents, she graduated from Vassar College and obtained a doctorate from the University of California. She has taught social anthropology at the University of Washington, and at Sarah Lawrence, Pomona, and Vassar Colleges and has served as consultant to the Midcentury White House Conference.

◀ *the authors*

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MAKING HOSPITALIZATION EASIER FOR CHILDREN

HENRY H. WORK, M. D.

Department of Psychiatry, School of Medicine, University of California Medical Center, Los Angeles

FOR OVER A CENTURY hospitals and hospital facilities for children have steadily increased. They have grown larger, more efficient, and presumably better equipped to meet the needs of their small patients. Whether they have always offered the best kind of care for children is not so clear.

Certainly, the child who is ill may be in real misery and appropriate treatment may relieve him of this or a considerable part of it. Therefore, the hospitalization of a child may seem completely justified by making more readily available to him the services he needs to make him well.

The fact that coming to a hospital, and so leaving home, may add a futher source of serious distress to the child has not always been so well understood, nor considered in the services offered. While a certain amount of homesickness in child patients has been accepted as inevitable by hospital staffs they have tended to regard this as something the patient and those who serve him must endure.

Many persons who work in hospitals for children have become gradually indifferent to the distress of children, perhaps in an attempt to inure themselves against the full impact of each child's disturbance, or because they find it "disagreeable to feel that children are very unhappy in their care."[1] Confident that the activities they are carrying out have been designed to alleviate the child's suffering, they may resent any interference with their way of doing things and adopt a proprietary attitude which excludes even those who normally care for the child.

Such hospital habits, however, are now being challenged with the stimulus of new knowledge about children which has been brought to light through several studies made in the past few decades. Included in the challenge is the question of whether hospitalization in itself is not a bad experience for children under any circumstances at all and one that ought to be used as sparingly as possible.

One group of studies relates to the normal developing relationship between parents and their children and particularly between a mother and her child. They have underscored the intrinsic worth of this relationship through all kinds of circumstances, the healthy and normal maturation of the child as well as the difficult periods of illness or personal trouble.

The other group of studies includes data based on very direct observations of children who have been separated from their normal relationships and exposed to new and different kinds of experiences and emotional ties through hospitalization or institutionalization. The careful observations of Bowlby in England,[2] and of Faust [3] in this country have particularly led to a new consideration and appreciation of what separation from family can do to a growing child. These studies have been complemented by others which have explored the relationship of a mother to her newborn baby.

In the light of present knowledge, the Committee on Hospitals and Dispensaries of the American Academy of Pediatrics has issued a statement reading in part:[4] "It is recognized that the best hospital cannot be a complete substitute for a child's home. Nonetheless, the need to provide as homelike an environ-

All around the country today boards and staffs of hospitals are thinking about ways of minimizing the emotional dangers of hospitalization for children. The reasons for this concern and steps it has led to in some hospitals are presented in the group of articles opening this issue. British experiments to approach the problem from another angle—keeping children out of hospitals as far as possible—are described on page 91.

ment as possible must constantly be kept in mind. Hospitalization may be a major emotional experience for the child. No matter what the age of the individual, during illness there is a tendency to regress to more dependent and less mature modes of feeling and behaving. It is recognized that infants and younger children need their mothers and that separation is not desirable when this can be prevented."

Hospital Procedures

What then is being done to alleviate the distress of hospitalization for children?

Three major interrelated areas of contact between the child and the hospital have been the subject of study and experimentation. One includes procedures designed to eliminate force or even actual pain in the contact between the staff and the child. The second is focused on ways of preparing the child for hospitalization. The third concerns methods of continuing close contact between the mother and child, by including her and other members of the family as a part of the hospital environment.

This last area of study arouses the most controversy among hospital administrators and meets with the most resistance from hospital staffs. Curiously, the presence of parents and relatives in a hospital up to now has been closely related to the sophistication of the service as well as to the cultural patterns of the country in which the hospital is located. In many parts of the world hospital visiting is a normal and simple experience for all members of the family, who come in with the patient, camp there and become a part of the hospital setting. In this country, as in northern Europe, hospitals have tended to remove the relatives and limit contact to occasional visiting rather than living with the patient. Separation has appropriately been carried to extremes in hospitals for contagious diseases, but unfortunately practices inaugurated in some of these hospitals have been carried over to general hospital facilities for children where the need for exclusion of normal contacts is not so apparent. The excuses for this carryover are given mainly in terms of efficiency.

Recent efforts to modify the separation of family and hospitalized child have chiefly been in the direction of longer and more frequent visiting hours and, to a lesser extent, of taking in the mother as a resident in the hospital during the illness of the child. This latter practice was introduced in England by Sir James Spence some years ago. Until recently, however, a similar move by Dane Prugh at the Boston Children's Hospital begun in 1949 [5] has been regarded as highly experimental. Today, however, an increasing number of hospitals are trying out ways of keeping mother and child together as much as possible during the latter's hospitalization.

In 1954 the Citizens' Committee for Children of New York City undertook to explore the frequency and length of visiting hours on children's wards of New York City hospitals, both public and voluntary.[6] It found that visiting policies among the 75 hospitals ranged from every day in 32 percent of the hospitals to one day a week in 4 percent of the hospitals. Besides such data, the survey brought out certain questions and problems in regard to a more flexible policy in the minds of those in authority. These showed considerable concern about the physical plant and the strain that extra people would place upon it, and some, but much less, concern about the dangers of cross-infection. They also revealed a prevalent feeling among hospital personnel that parents might abuse privileges if these were given—an old and important fear, frequently expressed by nurses and physicians who are afraid that parents will bother them and even upset their own children. Finally, the survey found, one of the major factors in changing any visiting policy was a general inertia.

When Parents Visit

On the positive side the study showed that in those hospitals where hours had been liberalized parents had not abused their privileges to any appreciable extent. The report pointed out that in all hospitals, whatever the rules, a few parents caused trouble, and it gave evidence indicating that less of this kind of trouble existed in hospitals which had "more flexible schedules and a firm, consistent approach to the disturbed parents' demands." Apparently in such hospitals the parents feel more good will towards the hospital and are therefore more willing to cooperate with the rules.

One salubrious byproduct of flexible visiting hours found by the study was the disappearance of peak periods of visiting and hence lessened demands on the personnel. Another valuable byproduct, noted in the teaching hospitals, was the opportunity such a policy afforded residents and students for seeing the whole family group and thus developing a much broader concept of pediatric practice.

A long-time objection to periodic visiting hours has been the disturbance in the wards at the time of departure. When mothers leave at the end of the visiting period the children become upset, restless, unhappy, cry a great deal and even have temperature changes. This experience has been used as an argument against more frequent visiting hours. But, the study indicated, where visiting hours had been liberalized the child seemed to have less of a feeling of desertion and did not cry for so long.

The study also pointed out some very important problems in connection with more flexible visiting policies. Where visiting is unlimited and the mother is expected to be with her child, it is possible that she may neglect her other duties in doing so. Sir James Spence found the answer to this problem in the community in which the parents lived, pointing out that household responsibilities and the care of other children could be assumed by neighbors.[7] However, neighborly mores are different in many parts of this country—especially in large cities—from those of the city where Sir James made his observations.

Another, and more important problem is the strained relationship which a mother may develop with her child when she feels compelled by duty to be with him while he is in the hospital. Obviously, one cannot arrange for a liberal visiting situation, or the possibility of rooming-in, without arousing guilt in some mothers who feel that if they do not or cannot take advantage of this arrangement they are thereby failing their child.

Often when a child who has been growing ill at home is finally transferred to the hospital parents feel a great sense of relief. They may compensate for the anxiety and annoyance they felt in taking care of him by a strong feeling of irritation when they are excluded from his care in the hospital. If, however, they can be welcomed as participants, without being expected to be the sole moral support of the child, their guilt may be assuaged. This has been described by Frey in her comments on "engineering to reduce fear in children." [8]

In experiments such as those of Prugh and Spence, in which the mother was an active participant on the ward, helping to feed and care for her child, the mother became an integral part of the child's hospital experience as well as a helpful aid to the staff.

The Child's Needs

In considering hospital policies it is well to review what happens to a child when he is separated from his mother. Bowlby has observed: "One fact which seems to emerge is that almost all very young children who are placed in this situation cry. They make it quite clear that they want their mothers back, and protest to get them back. This phase of protest continues more or less overtly for a period which can vary from a matter of hours to days." [1] This is followed by a period, varying in extent, in which children go into an "apathetic, inert phase," as though they were in despair or depression. Finally, when a child has been in a hospital over a long period of time with scant contact with his parents comes a stage described as "adjusted." Bowlby notes that this period is hailed with relief by staff members caring for the child, who tend to point out that he has become happy in the hospital. Bowlby's own observations, however, suggest that the child has finally put away the image of his parents, particularly his mother. He cites a few dramatic instances where a child on returning home has been unable to identify his mother.

This playroom at the Boston Floating Hospital, run by a nursery-school teacher, provides space and equipment for ambulant children to choose among a number of activities.

It is now generally felt important for the small child not to be unduly separated from his parents when it is necessary for him to go to the hospital. Obviously, this is sometimes unavoidable, but certain priorities for a policy stand out. One is the child between the age of 12 and 36 months. At this age a child has few resources to help him cope with separation and has not as yet by any means got over his dependence upon his mother. It is more important for him to have an opportunity to be with or be helped by his mother than for older or much younger children.

Certain hospital experiences place more of a strain upon a child than others. Included are many kinds of operations—for example, eye surgery, which renders the child incapable of maintaining sensory contact with his environment. Whenever the frightening aspects of hospital care increase, the need increases for the child to have normal contact with his mother.

On the other hand, there are also definite contraindications to visiting. The child patient coming into the hospital needs rest as much as any adult. If the presence of the mother can increase the child's ability to rest this becomes of real importance. However, the mother herself may be so worn down or so guilty that she cannot cooperate with the hospital and keeps her child from resting. In certain instances the illness itself seems to have some relation to the mother's anxiety, thus requiring the child to have a different kind of care than she could give. This is not easy to judge. Nevertheless, the decision to restrict visiting should be made, not in response to staff irritation, but in view of the nature of the actual mother-child relationship, as determined by clinical observations.

Few places with liberalized visiting hours have found these changes well accepted by *all* of the staff, for nearly always they threaten the emotional needs of some individual staff members. Some physicians worry about losing their immunity from lay "interference" and some nurses may unconsciously regard their patients' mothers as competitors.

No matter how careful the hospital is about keeping the trauma of hospitalization to a minimum, it is bound to be a terrifying experience to some children. In recognition of this, as well as of the child's normal need to associate with other children, a few hospitals have been experimenting with group therapy and play groups to give children a chance not only for diversion but for acting out or expressing some of their feelings about the experience.

Most important in introducing any change in a hospital are efforts to create staff understanding of what it will involve. Perhaps this can best be obtained through staff discussions of what the individual members can expect to happen and what they can do about it. Through such discussions the concepts of the use of such procedures can be interpreted and individuals can be given a chance to talk out their irritations against parents. In this way the staff can arrive at an understanding of which parents can best be served and which children will be helped the most by the new procedure.

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What Some Hospitals Are Doing

A THREE-WAY PROGRAM

PROCEDURES FOR HELPING children adapt to hospitalization have been continuously tested in the Children's Hospital of the East Bay in Oakland since 1950. These efforts have been mainly in three directions: preparation of parent and child before admission; a relaxed visiting policy; encouragement of parent participation in child care.

On the day of admission the parent, usually the mother, fills out a routine record form designed to help her think about certain aspects of adjustment to the hospital, and to provide the staff with information about her child, such as his nickname, toileting habits, sleeping and eating patterns, previous separation experiences and her own plans for visiting him.

A special information booklet, *What My Parents Should Know*, given to parents before the child's hospitalization, suggests that the child would be helped by knowing beforehand such things as how a hospital bed differs from his own, that baths are given in bed and meals served on a tray, that toys and games are available, that picnic lunches are given once a week in bed.

A special pamphlet focusing on the child who is to have a tonsillectomy, issued in 1951, took a year of preparation. Called, "Going to the Hospital" it was developed by a committee of the medical staff, representatives from the nursing, occupational therapy, and psychological medicine staffs, members of the publicity committee of the Board of Directors and the hospital administrator. Illustrated with simple pen and ink drawings, the pamphlet is designed to stimulate the child to use his own fantasy and balance it with the detail of reality and to encourage him to ask questions of parents and physician before coming to the hospital. Copies are given to the medical staff of the hospital for distribution on the understanding that they are not to be used as a substitute for communication by the physician to the child or his parents.

A year ago the daily visiting period was increased from 1 hour to 1:30 to 7 p. m., with special permission given for morning visits. Parents are urged to visit their children before surgery and to see them as soon as they awaken from the anesthetic. When a child is critically ill, the parents may stay with him or visit at any time of day or night. A few rooms are available for rooming-in.

In the infant wards, diapers are always handy by each bed so that parents may change them during visiting hours. Parents are encouraged to feed their children during feeding times, and to hold them if the medical or nursing problems permit.

Older children are encouraged to be as ambulant as possible. Ward cliques or "pal" pairing of children are fostered by nurses and occupational therapists.

When children's or parents' emotions present nursing and administrative problems ward seminars led by representatives from the hosplital's Child Guidance Services or senior nursing staff are held to attempt to clarify the reasons for the behavior and decide what might be done.

Not long ago a father insisted on taking over the entire nursing care of his son who was slowly dying of an inoperable brain lesion. At first the feelings among the nurses and resident physicians were quite mixed, but after reviewing the information on hand about the father's relations to his son, they came willingly to support his action. Then staff members began to worry that the father would collapse emotionally when his child died. However, when death occurred the parents seemed able to take it fairly calmly. Another staff meeting was held to analyze the experience and discuss the helpfulness of letting the father prepare himself in this way for the death.

We have continually to reevaluate the effectiveness of all our procedures for meeting the needs of the hospital and of the parents and children who come for service, to insure that they are kept in dynamic balance.

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A COMPREHENSIVE APPROACH

A CHANGE IN ATTITUDES motivated by the acceptance of the concept of "the total care of the child," has occurred gradually during the past 10 years at the Boston Floating Hospital, a general pediatric teaching hospital. This has resulted in an organized play program and a visiting policy which encourages parents to visit daily and allows flexibility in the hours.

The relaxed visiting policy has had far-reaching effects by providing staff opportunity for frequent observation of the family group in action and so increasing staff awareness that the child is not an isolated entity but part of the family unit. The staff's close contact with parents has led to an empathy with their grief and anxieties and has replaced the former identification with the child with a family orientation.

The mental-health program developed originally as a part of the Pediatric Service. The Child Psychiatry Unit, organized later, now coordinates and supervises the total program. The details are subject to constant change because of the flexibility inherent in the comprehensive approach.

The admitting process is geared toward making the separation as gradual as possible. Parents are encouraged to follow their child to the ward, to see him settled in his crib and to get acquainted with the nurses. The mother fills out a questionnaire concerning the child's preferences and little habits, and care is taken that some toy or blanket which forms a link to the home is left in the crib. Beds are never moved without serious reason.

Daily visiting hours are from 2 to 3 p. m. and from 7 to 8 p. m. Parents who wish to do so may come at both times. Those for whom the hours are inconvenient can get permission to come at an hour of their choice. Those who want to stay all day or a part of the day must get permission from the pediatric house officer, who bases his decision on what he believes will serve the family's real interest.

Since last year the hospital has operated an experimental "living-in" unit. Mothers sleep in the same room or next door to their children and take an active part in their care. According to the nursing staff, the constant presence of the mother at the child's bedside is sometimes a challenging but in general a rewarding experience.

A play staff is interested in every child in the hospital. Play teachers make their rounds in the morning, stopping at every bedside and giving toys, games, comics, and books to the children. Patients who have medical permission spend most of their day in the playroom. The playroom service is essentially a non-directive activity program, supervised by trained nursery-school teachers. The child is given adequate space and play material with a freedom of choice to use them. On the ward play activities are handled by student nurses under the supervision of graduate nurses. Recently a play teacher helped the teen-age polio patients organize themselves into a "club," the members of which have regular evening meetings in their own club room.

The realization that the children tend to become increasingly anxious toward evening led to the establishment of an evening volunteer service. Four or five women volunteers arrive every evening at about 6 and stay until around 8. They read bedtime stories, play quiet games and give sympathetic companionship to the children.

The trend discernible at present is toward an increase of the living-in facilities and a further liberalization of the visiting time.

VERONICA B. TISZA, M.D.

Boston Floating Hospital, Tufts University

IN AN ORTHOPEDIC HOSPITAL

SINCE 1943 the social workers at the Hospital for Joint Diseases, a general hospital specializing in orthopedic surgery, have interviewed all patients referred from its outpatient departments for ward care. These preadmission interviews help to resolve problems around understanding and acceptance of medical care. The data they provide are entered on the medical charts and serve as a base for medical-social discussion on medical rounds, continued casework service, predischarge and discharge planning and rehabilitation planning.

The parents of all children and adolescents referred for inpatient admission are interviewed, as are children old enough to talk about their feelings about entering the hospital. Frequently, the social worker takes a child to see the children's ward. When this happens physicians, nurses, occupational therapists, "play ladies," medical residents, hospital teachers, and others extend a warm welcome. The children usually react positively and some even express a wish to remain.

About a year ago the hospital inaugurated a policy of allowing daily visiting to children, with hours set for 1 to 6 p. m., but exceptions often granted. Formerly visiting was twice a week.

Since children with orthopedic disabilities remain in the hospital for extended periods the daily visiting has been a boon to treatment. For the children it has greatly mitigated the fear provoked by the separation from their parents. The afternoon hours were chosen since in the mornings the children generally receive their medical treatment, school work, and other routines and also because they encourage visiting by fathers. Parents with permission to visit in the morning help with feeding and caring for the youngsters. Those who visit in the afternoon attend at least one meal. Parents enthusiastically follow the nurses' instructions. They help not only with their own children, but also with others whose parents have failed to show up. Children often invite other children's parents to visit with them.

However, some children do cry when parents leave and some members of the staff find this daily crying period difficult. But the crying does not last long, for knowing that his parents will come again the next day a child is usually easily soothed.

The chief nurse on pediatrics, the senior social worker from pediatrics, the children's occupational therapist, and the hospital teacher daily discuss the integration of their services with parent-visiting, often calling in the medical residents. They are also writing a book about the hospital directed to the child patient, hopefully to be read by the parents to or with the child who is about to enter the hospital. Child patients are participating in the preparation of this booklet by expressing their own thoughts and feelings about hospitalization.

In the spring of 1953, the hospital initiated a cooperative program with the Bureau of Physically Handicapped of the Board of Education, the Division of Physically Handicapped of the Department of Health and the New York City office of the Division of Vocational Rehabilitation in an effort "to assure continuity of medical care and to help meet the psychological, social, educational, vocational, and recreational development of each child treated by the hospital." Under this program workshops on "Orientation," "Communication," and "Intercommunication" have been held at the hospital, under the joint auspices of the agencies. Participants have been physicians, teachers, nurses, trustees, social workers, school principals, school superintendents and others.

SADIE SHAPIRO

Hospital for Joint Diseases, New York

A RECREATION PROGRAM

THE RECREATION PROGRAM at the Children's Hospital in Cincinnati is set up to meet the needs and interests of all the patients. It provides morning, afternoon, and evening activities for children who must remain in bed as well as for those who may go downstairs for group activities. A part of the nursing department, the recreation staff consists of six full-time people, three trained in child development, two in elementary and art education, and an in-service trained nurse-aid who works in all facets of the program. They work closely with the nurses in planning activities for the children as well as in the selection of toys and play equipment.

Many of the program's unique features are possible solely because the hospital receives annually a large gift of money in response to a television appeal by a local TV personality. In addition to television sets, motion picture equipment, and innumerable gifts of toys and dolls to individual children, the salaries of three full-time recreation workers and the children's librarian also come from this fund. The hospital pays the salaries of the recreational director and nurse-aide.

Some 40 volunteers help directly in the program for 2 or 3 hours once or twice a week. Volunteer groups outside the hospital help in providing play materials, such as tray favors, stuffed toys, doll clothes, scrapbooks and used toys.

One of the most popular activities is the Get-Well Club for patients from 10 to 16. The club meets in the playroom on two evenings a week except during the summer when meetings are held in the play yard. To be a member a child must be able to leave the ward though he may attend on foot, in bed, or on a cart. A new member receives a membership card and a "beanie" in club colors which he wears to all meetings.

The club elects a president, secretary, and sergeant-at-arms. It has written rules and regulations drawn up by the members and subject to revision at any time by the group.

On Wednesday, the club members meet at 4:30 and stay for supper. The Dietary Department prepares the meal the children have planned and sends it to the playroom. Some items, such as desserts and salads, are left for the children to prepare themselves. The children set the table and serve the food. After a brief business meeting, activities begin—games, crafts, a television program, or special entertainment from outside the hospital. On Fridays club meetings start after supper.

Children of all ages come to the playroom at 9:30 every morning for 5 days a week. At 11:30, older children return to their floors for lunch; those from 3 to 6, for whom continuity and consistency are necessary, remain in the playroom for toileting, a period of quiet activities and for lunch at 12, and return to their floors at 1 for rest hour.

A children's library with nearly 3,500 books and a full-time librarian is designed to meet the reading interests of children of every age. Reference books are also available for those with school assignments. The librarian visits all floors with a book cart daily so that children who do not come to the library may make selections. She also conducts discussion groups in which the children talk about books they have read and listen to reports of new ones.

While the outpatient department has had a playroom for many years, we have only recently introduced planned activity for children waiting to be admitted to the clinic session. During the past year the children's librarian has shown story film strips in the outer waiting room. This has greatly helped in the smooth operation of the outpatient department.

PATRICIA O'REILLY

Director of Recreation, Children's Hospital, Cincinnati, Ohio

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AT A RURAL HOSPITAL

THE OPENING of a rural medical center in Hunterdon County, N. J., in July 1953, provided an opportunity to develop an in-patient pediatric service whose philosophy of operation was uninhibited by previous traditions, taboos, and fears. Encouraged by a sympathetic hospital administration and director of nursing, the director of pediatric services established a policy from the first of allowing unrestricted visiting for parents of hospitalized children, and making sleeping arrangements available for mothers or fathers who wished to spend nights with their children. The admission procedure was designed to include parents as part of the therapeutic team and to maintain the connection between parent and child as far as possible, even in those cases in which the parents were unable to stay.

Thus nurses were recruited for pediatric positions with full knowledge of the proposed policy. The employment interviews stressed the importance of the pediatric nurse as an observer of behavior and of parent-child relationships.

This pediatric policy was announced to the public in various ways before the opening of the hospital.

The plan was put into effect with the full cooperation of all concerned. After nearly 3 years of operation, the results have been gratifying. The nursing staff quickly appreciated the comforting effect of mothers on their hospitalized children. It soon became apparent that the floor was noisiest and unhappiest when inhabited by a group of unattended babies and toddlers. Furthermore, mothers clothe, feed, bathe, and entertain their children, thus relieving nurses of considerable routine work.

Medically, aside from the markedly salubrious effect on the psychological trauma of hospitalization, the opportunity provided by the policy for observation and evaluation of parent-child relationships has often led to more accurate diagnosis and hence more effective therapy. The resident staff has profited greatly by this exposure to pediatric practice as it really is.

Finally, we are learning, on occasion, to manipulate visiting hours so that, in working with certain types of behavior disorders, short periods of trial separation from parents can be utilized constructively. Thus, with medical and nursing personnel working in close collaboration with our child guidance group, consisting of child psychiatrist, psychologist, and social worker, the pediatric service is functioning somewhat as a short term residential treatment center.

In summary, experience at Hunterdon Medical Center with visiting hours unrestricted administratively and manipulated therapeutically has been eminently successful. The usual fears for such a program have not materialized. The occasional problem of the disturbed or "difficult" parent exists. But we attempt to deal with such situations in a professional and diagnostic manner, with the full realization that such parents pose problems even when excluded from the hospital.

The program continues to have solid medical, nursing, and administrative support.

ANDREW D. HUNT, JR., M.D.

Director of Pediatric Services,
Hunterton Medical Center, Flemington, N. J.

Extension of home nursing is an important facet of . . .

BRITISH EXPERIMENTS IN THE CARE OF SICK CHILDREN

LEN M. CHALONER, M.B.E.

THE LATE Sir James Spence, Professor of Child Health at Durham University in England gave the United Kingdom a great stimulus toward new methods and research into the care of sick children. Even before World War II he had developed the revolutionary practice at Newcastle Infirmary of having mothers nurse their own very ill children in special small hospital units and had found it of great benefit not only to child patients and their mothers, but also to the hospital. Under his direction the mothers frequently took their children straight from the operating theater and cared for them day and night under the guidance and support of physicians and nurses who carried out all the medical treatments.

Spared the experience of separation from his mother at such a time of stress, the sick child, Sir James maintained, recovered more steadily and without setback, while his mother gained in insight and confidence through bringing her child safely through his ordeal. She was also able to care for him better during his convalescence at home through having been in close touch with his illness from the start.

Though at first some of Sir James Spence's ideas were looked on as too revolutionary, the increased understanding of child development and its needs that came during and after the war years, brought them fresh consideration. The pioneer work at Newcastle undoubtedly paved the way for the three research projects and experiments now being carried out in England in three different centers to discover how far it is practicable to nurse sick children in their own homes under the care of visiting doctors and nurses. This does not include care for children needing special treatment that only a hospital can provide.

These undertakings are carried out under the National Health Act by the local Health Authority, the local hospital, and local family doctors. Naturally, the Ministry of Health is very much interested in the schemes. It is very usual in Britain for experimental work and research to be pioneered in this individual fashion and if found successful to be extended on a national basis later. The present independent schemes allow for variation in administration and detail that adds considerably to their value.

The aims in each case, however, remain much the same:

1. To save the young child the traumatic experience of early separation from his mother and family which is found so often to have adverse effect on his subsequent development.
2. To help the mother gain a practical understanding of hygiene and home nursing which will be of great value to the rest of her family.
3. To save the young child the risk of cross-infection in a large ward, which can sometimes arise in spite of every care.
4. To ease the demand on hospital beds so as to save waiting time for patients needing treatment that can only be provided in hospital. It might be added here that the Paddington experiment (described

later) has shown that the cost of treating a child at home under this scheme is less than in a hospital, whether estimated as cost per case, or cost per patient week.

In Rotherham

One of the home nursing services for children was started in Rotherham, Yorkshire, in 1949, and therefore is past the experimental stages. Two home nurses with special training and experience were chosen for the children's unit, which is part of the local Authority's general home nursing services and works from the Authority's headquarters.

The decision to have a child nursed at home rests with the family doctor. At his request one of the nurses or the home nursing superintendent calls at the home, sees the child and his mother, assesses the suitability of the home for the service, and learns what equipment may be needed to make home nursing possible. Extra bowls, jugs, and sometimes extra sheets, nightgowns, or napkins are available on loan for the emergency. If the nurse feels that the home is quite impossible from the practical point of view, she discusses this with the superintendent or the doctor who may refer the child to the hospital. But in the majority of cases the nurse is able to manage with some additional equipment and to show the mother how best to improvise and make home care possible.

The nurse works in frequent consultation with the doctor in charge of the case, informing him at once if the child is not responding to treatment. All the treatments ordered by the doctor, such as injections and dressings, are carried out by the nurses, as is all general nursing care during the first few days until the nurse sees that the child is improving and the mother understands and is able to take over such routine. The number of visits that a nurse pays to a child varies with the nature and progress of the illness. Sometimes she goes as often as four times a day. The child's parents are told that if the child's condition changes, or gives any cause for anxiety or misgivings at night or at any other time not to hesitate to phone the superintendent's office to send a nurse along. This assurance has been found to give considerable comfort to the parents. The night calls have been few and usually justified.

The majority of the doctors in the Rotherham area have readily availed themselves of the special service. In winter, when the demands have sometimes been beyond the capacity of the two special nurses to meet, additional nurses from the home nursing services have supplemented the care, working in cooperation with the children's unit. Opportunity has also been given for student nurses to gain insight into this work. The two special nurses have taken short refresher courses at the hospital to keep them in touch with modern methods and techniques. As soon as the child no longer needs nursing care the health visitor, a public-health nurse, is notified for follow-up purposes.

During the 6 years the scheme has been in operation, the demands on it have steadily grown. In 1954, the service took care of 690 cases through 6,800 visits.

In Birmingham

Birmingham's scheme has been working for only a little over a year so that those in charge of it still regard it as experimental, though promising in its results to date. It came into being through meetings at the Birmingham Institute of Child Health, where it was realized that many sick children would not need to be admitted to the hospital if the early stages of illness were better cared for and that the frequent return of certain children to the hospital could be avoided if better follow-up arrangements could be made.

It was decided to limit the first experiment in

Held in his mother's arms amid the familiar surroundings of his own home in Rotherham, this sick child seems free from fear as a home nurse carries out the doctor's orders.

Birmingham to the area around the Children's Hospital, including a population of about 100,000. The provisions of the program are rather similar to those of Rotherham, in that it is part of the home nursing services of the local Health Authority. Two specially qualified nurses were appointed by the local Health Authority and sent to the Children's Hospital for a short term to get to know the staff and become familiar with the methods there. However, they work from the district nurse's headquarters in the usual way.

In Birmingham, as in Rotherham, the family doctor decides if a child can be nursed in his home and calls in the nursing services. But in Birmingham the doctor may also, if he wishes, call in a specialist from the hospital for consultation and the hospital may refer a casualty or out-patient case to the family doctor for home nursing. This makes for very close cooperation and liaison between the family doctors and the hospital. Of the 220 children nursed to date, 204 were referred by the family doctors and 16 by the hospital. The nurses paid 1,541 visits to these patients, going into the homes, as in Rotherham, both by day and by night as needed.

In London

The third scheme, a research project first undertaken for a year by St. Mary's Hospital, Paddington, in conjunction with the London County Council, aims at discovering how far and under what conditions seriously ill children can be successfully nursed in their own homes. Recently, it was decided in the light of the first year's experience, to carry forward the work for another 2 years, as 12 months were regarded as insufficient for clarifying the results.

The research is at present limited to the crowded and rather poor district of Paddington, but this has had the advantage of making for a minimum expenditure of time and transport in moving from case to case. The team set up to carry out the project consists of a part-time pediatric specialist, a full-time pediatric registrar, three specially qualified nurses from the hospital staff, who maintain a 24-hour nursing service as required, and a physiotherapist. The pediatric registrar acts as medical link for the team. By means of this team the home can become virtually an annex of the hospital ward.

The function of the team is to help the family doctor in his care of the child, who remains nevertheless the family doctor's responsibility. Usually new cases are first seen by the pediatric specialist and the family doctor in consultation, after which the doctor uses the team at his discretion. Medical and surgical cases from the hospital, discharged before treatment is completed, are also supervised by the family doctors with the help of the team. As in Rotherham and Birmingham the nurses carry out the medical treatment and help the mothers to learn and take over the bedside nursing.

A health visitor and a Queen's nurse, selected in Rotherham for the children's unit of the home nursing service, receive pediatric instruction in an out-patient clinic.

Most of the mothers have proved observant and reliable as nurses. Very few have complained of the extra work involved. Several in fact have said that the home care program makes things easier by saving them from anxiety and the burden of visiting the hospital. From the hospital's point of view it has also been found that the parent's way of life matters more than their housing arrangements.

Some of the mothers have gradually learned from the constant visits and example of the nurses to improve their standards of housekeeping, and others have gained confidence in meeting minor ailments and emergencies so that in future serious illness they will be more apt to call in their family doctor instead of getting in a panic and rushing their child into a hospital. Some too have said they have gained a better understanding of how their child had become ill and so feel confident they can prevent a recurrence. Had the child been sent to the hospital he might easily have been returned to the original conditions that first made him ill.

St. Mary's Hospital, which is a teaching hospital, regards the home nursing service with its regular visits to family homes as offering valuable teaching possibilities at postgraduate level for future consultants and prospective general practitioners. Those making the examination of a child in the presence of the parents need to be highly skilled and extremely careful in all procedures.

As the Paddington project got into its stride, the number of cases directly referred by family doctors increased while those referred from the hospital wards lessened. Of the family doctors in the area using the scheme on their own initiative, 3 used it in more than 10 cases, 3 in from 5 to 10 cases, 14 in from 2 to 5 cases and 18 on 1 occasion only. Interestingly, 24 of the patients were infants, and 33 percent were toddlers between 1 and 4 years—the two groups generally regarded as best kept out of a hospital if possible. The illnesses included respiratory and chronic chest diseases, intestinal infections, some infectious diseases and some chronic ones where the child would otherwise have suffered prolonged separation from his family. Of the 209 children served under the scheme, 193 were nursed at home throughout their illness, 10 were admitted to hospital for part of their treatment, and 6, after a domiciliary consultation, were considered not to need the services of the home nursing team.

Other Experiments

Home nursing schemes can obviously play only a limited, though valuable, role in meeting the needs of sick children. Fortunately, in Britain experiment and research are also quietly extending in the effort to bridge the gap between home and hospital for child patients when in-patient care is needed.

Although so far no other hospital has followed fully the patterns of Newcastle Infirmary, somewhat similar though unofficial arrangements prevail in many places.

For example, in the Southwark, Bermondsey, and Rotherhithe areas of London it is not so unusual for a mother to be admitted with her young child to Guy's, the Evelina or St. Olave's hospitals. Within these hospitals a mother does not live wholly apart from her baby, meeting him only for the brief occasion of his feeding, but at the discretion of the doctor is allowed to give him some routine attention and companionship. At the Children's Hospital in Sheffield, where 10 to 12 small units are reserved for mothers who are especially upset over their child's being hospitalized, or whose children are especially upset at being "left," the staff has found the mothers to be extremely grateful for the opportunity. They are allowed to give all routine care of feeding, amusing, and putting their children to sleep. The hospital has found the arrangement particularly valuable in helping mothers of babies ill as a result of severe feeding problems to regain confidence in their ability to manage the feeding.

The Ministry of Health has for several years given official encouragement to the child patient's closer contact with his home, by asking hospitals to make every effort to allow daily visiting by parents. Through frequent visiting, it is believed, even very young children—who cannot really understand the need for hospital internment however it is explained—suffer less and come to realize that they are not wholly rejected by the people at home. Mother has not gone "forever," but only "till tomorrow." In 1952, out of 1,362 hospitals admitting children, only 25 percent permitted daily visits. By the end of 1954 the portion permitting daily visiting had risen to 63 percent, while 75 percent of the remainder were allowing visiting three times a week.

Sir James Spence stressed the fact that whatever changes come about must be allowed to grow slowly, not as the result of external pressure upon hospital personnel, but through the realization of the value of a greater sharing with parents in the care of sick children.

No one method, of course, can provide the whole answer to the needs of child patients, for the circumstances must always be individual from the point of view of the illness, the child's own personality and background and the hospital itself, so that the more flexible the possibilities for his care the better. Sir James was most fully aware that not all cases were suitable to be nursed by their mothers at Newcastle Infirmary, that some mothers might also have duties to other children in the family to keep them at home. The present on-going experiments are a conscious pilgrimage of trial and exploration in the sincere attempt to find at least some of the answers to the problems of caring for sick children in our rapidly changing age and society.

A psychiatrist who heads a large public institution presents some thoughts on . . .

WHAT HOSPITALS FOR THE MENTALLY RETARDED CAN ACHIEVE

GEORGE TARJAN, M. D.

Superintendent and Medical Director, Pacific State Hospital, Pomona, Calif.

THE TWO THINGS that institutions for retarded children have in common are long waiting lists and a wide range of problems. Otherwise they vary considerably in their function, approach, and remedial techniques, and even in the type of population they serve. Many include only a small segment of the multitude of diagnosed conditions and complicating handicaps found under the uniform label "mentally retarded" or "defective." Nevertheless, even in these, the range of conditions among the patients is broad.

In almost all institutions, public or private, there are patients with relatively high and extremely low endowments. There are patients with superimposed neuromuscular or skeletal abnormalities, those who suffer from epilepsy, those with physical stigmata, and those who differ little in appearance from other children. Though deviant from the normal in many respects, all are human personalities with needs at least as complicated as those of children everywhere.

In the not too distant past, the severely retarded child had but a slim chance to survive to school age. His need for specialized medical care went unrecognized and he remained at home, except in the most unusual circumstances. Institutions had no plans for him; in many States he was actually excluded from programs. In those days the majority of institutional residents came from the mildly or moderately retarded groups. A pessimistic outlook on prognosis frequently resulted in their lifelong seclusion from society.

Recently, however, a shift has been taking place in the composition of institutional populations. Advances in diagnostic methods, greater knowledge of disease control, the discovery of life-saving drugs, have all contributed to an increased life expectancy for the severely defective child, while the process of urbanization with its more crowded living conditions and growing employment of mothers has added to the difficulty of caring for him in the family unit. As a result, doctors and others have tended to recommend his separation from his parents by way of institutional care. Under this pressure the institutions have had to revise their programs to take greater cognizance of the severely retarded. In the meantime other developments have lessened the need for institutionalization of the mildly and even moderately retarded.

New trends in the philosophy of public education have contributed to this change, at least in some areas. Most public schools used to limit admission to children of average or greater intelligence, and children with mild or moderate mental retardation had to be placed in institutions, if they were to get any schooling at all. In recent years a more liberal interpretation of children's educational rights has brought about programs for the mildly and moderately retarded in many school systems, so that such children do not always have to leave the family circle for schooling.

This shift in intramural populations toward the more severely retarded, more physically handicapped, and younger children confronts institutions for the mentally retarded with the necessity of reviewing their philosophy, purposes, goals, and therapeutic techniques. Institutional programs in a number of places today are beginning to reflect some of the thinking produced by this challenge. In each place the emphasis and direction have inevitably been influenced by the individual character of the institution, its population and its staff as well as by the degree of concern throughout the State for what happens to the mentally retarded.

No institutional administrator can bring about a Utopian program by merely designing a blueprint. Always he will be surrounded by barriers of costs, professional shortages, and scientific unknowns that can only be partially surmounted.

As a psychiatrist in charge of an institution presently housing about 2,700 mentally retarded children and adults I have arrived at certain conclusions of what an institution for the mentally retarded should be. These were influenced by my experiences and orientation. In presenting them I do not claim that they represent the only way of meeting the needs of the mentally retarded. Nor can I pretend that we have realized all of them at Pacific State Hospital, nor that what we have achieved there has not been achieved elsewhere. If I use illustrations from that institution it is because its program is the one I know best. If I refer to adult patients, too, in this journal focused on children, this is because the very nature of mental retardation—which keeps children from becoming adults—makes it impossible for age to be a criterion in plans for the mentally retarded.

Basic Concepts

My first conclusion is that the proper role of an institution for the mentally retarded is to serve as a hospital for those whose condition requires psychiatric or somatic therapy, constant nursing care, or close observation. Education, social work, psychology, the rehabilitation therapies, and several other disciplines play an important role in the total therapeutic approach. They are also a part of the program, in order that the child who can profit by them is not denied advantages he would, but for his hospitalization, get in the community. Such a hospital needs specialized medical facilities with carefully developed programs, selected tools, techniques and especially trained personnel.[1] Ideally, all treatment and program is directed toward one goal—helping each patient to reach the maximum of achievement and independence his mental capacities will allow.

A psychiatric technician at Pacific State Hospital gives a child a bath with the aid of a "horizontal shower." Some children are bathed, necessarily, several times a day.

The criterion for admission to such a hospital is the condition of the child in relation to the ability of his parents and the community—emotionally and physically—to provide him the care he needs. This does not limit the hospital to care of the severely or moderately retarded for the difficulties of being even a mildly retarded child at times produce emotional disturbances which in some cases are more amenable to treatment in a hospital.

Certain general psychiatric concepts need to be kept in mind in the care of the mentally retarded child. His emotional needs are essentially the same as those of other children. To develop the maximum of his personality potentials he needs the benefits of a warm parent-child relationship. For this, early institutional care is at best only a substitute.[2,3]

On the other hand, emotional problems in the family can become a strong negative force in personality development. The birth of a defective child often acts as a trigger to many conflicts within or between the parents, resulting in strained family relationships. In some instances, separation of such a child from the family may be better than the uncritical maintenance of family unity—for in tense situations he is likely to be submitted to overprotection or overt rejection, either of which can greatly hamper his development.

Proper decisions as to whether or not separation is in order can only be made with the understanding of the forces that operate within the family. Here is where the hospital's own out-patient clinic becomes a necessity. In helping parents reach a decision the clinic, having a clear knowledge of the intramural program, can weigh the disadvantages of hospitalization against the problems of home care and can view the emotional climate of the family relation to both factors.

Mentally retarded patients are suffering from a chronic condition. Therefore their hospitalization usually is prolonged. This carries with it the danger that a routine, protective, and pathology-oriented milieu may act as an arrestive, or even regressive force. In daily living overemphasis of the handicap must be guarded against lest it become a psychological barrier forever in the way of maturation.

The hospital which accents achievement will find it necessary to revise many patterns inherited from custodial institution days. It will insist on trained and competent staff from the professional specialist to nursing personnel. It must find ways of selecting persons with a wholesome, warm, and understanding attitude toward the mentally handicapped and of training ward personnel within the institution. At Pacific ward "psychiatric technicians" receive a year of in-service training.[4, 5]

In a large hospital patient grouping is important since much of the therapy—environmental, physical, social, and even psychiatric—must be applied to a number of patients at once.

At Pacific we have found the most effective groupings to be functional rather than either diagnostic or age-based. The chief criterion is the answer to the question: What is the immediate goal of achievement? For the year-old, moderately retarded child and the bedridden, older child it may be the same—ambulation, to learn to get about in some manner. For others, adolescents or tiny tots, it may be toilet training; for still others, more advanced, to learn how to dress themselves, or even to learn to read and write. At Pacific the classification for placement in the 30 some wards takes into consideration the following criteria in order of priority: ambulation, habit training, sex (except for small children), and other factors. These, of course, are often interrelated.

Functional groupings help keep the accent on achievement, and thus provide a stimulus for both the staff and the patients. At Pacific this stimulus is kept alive by weekly case conferences on each ward of the personnel concerned with the ward program. This team includes the physician, social worker, psychologist, nurses, technicians and others.

We have found that achievement can be a goal for even the most helpless patient, for whom ambulation or toilet training may never be goals. Getting such patients out of bed each day and putting them near each other has shown us that they can become interested in their surroundings and one another. Some even learn to move about.

The Hospital Community

Schools in hospitals for the mentally retarded are of crucial importance. They must provide the kind of learning opportunities that retarded children can use. Classes should therefore be available for children of the various age and maturation levels who can profit by them. Some may concentrate on such simple things as how to button a button and tie a bow, while others teach children to read and write, and to develop vocational skills. The aim is to give the patients the scholastic, vocational, and social skills which will help them to live as independently as possible whether in the community at large or in a sheltered setting.

Heavy emphasis should be placed on teaching patients the elements of living in society which are not a part of working—what to do with leisure time, how to make friends, how to budget money. Unless this is done, discharged patients who succeed vocationally may get into trouble and have to return to the hospital.

Within the institution social exchanges and the development of warm interpersonal relationships should resemble those experienced elsewhere. If the patient is to cope with living in a less sheltered setting, he must learn during his years of development how to meet temptations, challenges, and frustrations as well as to exercise choices. The hospital that provides an environment which is entirely artificial can hardly expect a patient to assume even a semi-independent role later. Complete separation of age groups or sexes may decrease administrative problems but is not likely to contribute toward the future independent adjustment of the patient. A com-

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munity center with recreational and musical activities, a library, movies, dances, a beauty parlor, radio, and television, can greatly help to broaden interests.

With this in mind our program at Pacific includes a Rehabilitation Therapy Department which, with a strong groupwork emphasis, focuses on the provision of normal recreational and social experiences for the patients in a community center.

We also have a campus card system which enables a large percentage of patients to move about the grounds at will when not scheduled to be elsewhere. Since this means intermingling of the sexes on the grounds and in the community center, the inauguration of the system met with some warnings of trouble, which, however, have failed to materialize. We of course exercise more supervision than would be found in the normal community. We have also established a small store to give the patients a chance to exercise choice and practice in the use of money.

Work assignments within the hospital can be one of its most important therapeutic aspects if the emphasis remains on the therapy rather than on institutional maintenance. The therapeutic value comes from the feeling of usefulness the performance of the task brings as well as from the vocational preparation that might be involved. Assignments must, therefore, be individually selected as part of the patient's total program. We have found at Pacific that patients experienced in maintenance tasks can take their first step toward community living in paying jobs in private institutions. With the help of an industrial therapist appropriate job assignments are made and exploitation is avoided. All patients with job assignments have regular days off and are included in recreational programs.

One type of work assignment, currently being tried at Pacific, has a two-edged therapeutic purpose—to give nonambulatory young children the mothering they need and to give the moderately retarded young girl an outlet for her mother instincts. Each girl in this program is assigned one or more children who may be severely retarded, to feed and care for. The girls grow extremely fond of "their babies," even of those with gross physical manifestations of their defects, and cuddle and play with them with real spontaneity.

Religious opportunities are a part of normal life, and as such must be part of the hospital's program. Like many other institutions we have chaplains of the three major faiths at Pacific who not only conduct religious services but also participate in the total therapeutic plan.

Even in the healthiest hospital communities patients should not live in isolation from the outside world. This can be avoided by arrangements for group and individual excursions into the outside community, as well as by visits of outsiders to the institution. Individual contacts are the most important to foster, especially between the child and members of his family. Visits home help the child to retain his interest and skill in home living, and are important for the parent as well. Last year, over 1,700 patients, with varying degrees of retardation and superimposed handicaps went out from Pacific on short visits home. Last Christmas more than 800 patients went home for the holidays.

Other individual contacts can be arranged through a volunteer program. Of the many contributions volunteers can make to an institution the most important is the demonstration their presence affords of society's continued interest. The 50 some volunteers engaged in direct service at Pacific come from 3 groups: parents of retarded children; other persons with a personal interest in retarded children; and clubs.

We have found that group excursions do not have to be limited to the mildly or moderately retarded. Last year we took 1,300 patients to the County Fair during its 2-week run, many so severely retarded or infirm that they had to be escorted around the fair grounds in wheel chairs. We also take patients to the public parks, picnic grounds, and for bus rides.

Inpatient Therapies

When the total hospital environment is made as normal as possible special therapies for the amelioration of the patient's handicap have a better chance of succeeding. Sometimes the focus of medical and nursing energies must be toward maintenance of life. At other times the child's condition calls for greater variety in programing and may include surgery, physical therapy, seizure control, and individual or group psychiatric therapy as well as regular "well-baby" medical care and dental services.

The hospital's total treatment program should be guided by medical philosophy and involve a close relationship between patient and attending doctor on whom the major responsibilities for the individual's program lie. In all respects the hospital's standards should satisfy the professional organizations. Up-to-date techniques in the various medical specialties—especially psychiatry, pediatrics, internal medicine, orthopedics, neurology, and physical medicine—should be available.

Psychiatric service is of particular importance for the mildly retarded patient, whose need for hospitalization generally comes from superimposed emotional disturbances manifested in rebellious behavior. Intensive treatment upon admission is often effective and may result in early discharge. Release of emotional tension has been known to lift some children clear out of the category of "retarded."[6] Psychiatric observation of the relationship between parent and child can also be helpful in the staff handling of the severely retarded. Individual and group psychotherapy, play therapy, and the somatic treatment methods should be freely utilized as part of the armamentarium of psychiatry.

Because of the close relationships between emotional disturbance, mental disease, and mental retardation, a hospital for the mentally retarded might well have a ward for the psychiatric treatment of mentally ill, but non-retarded children. We hope some day to have such a ward at Pacific in addition to one we already have for children whose condition does not seem to fall into any of the more clearly defined forms of mental retardation.

Outpatient Service

Many of the problems of retardation can be handled on an outpatient basis. In most instances, proper diagnosis can be made in a clinic without help of intramural observation.[7] An outpatient clinic also gives the hospital physicians opportunity to make their special knowledge and experience available to the nonhospitalized. While the hospital needs an outpatient department of its own, clinic service can also be provided by community sources.

The contributions of the allied professions—social work, psychology, special education, physiotherapy, occupational, recreational and music therapy, dentistry, nursing, chiropody—should be well integrated into the program. Collateral treatment of the family is of primary importance in helping in the long term adjustment of the patient and assuring his reacceptance into the family circle.

In addition to the wards for the various age and functional groups, described earlier, the hospital needs a unit for infants. While it is generally agreed that group care is not the best kind of care for babies normally, many severely defective infants need hospital care in order to survive. For many, too, separation from their families is inevitable, and the question arises as to whether it might not be best for them as well as for their parents for this to come early.

Upon the establishment of the diagnosis a therapeutic relationship begins between the patient, the family and the hospital. The interpretation of the diagnosis to the parents, the working through of their conflicts around it, the acceptance of the implications of retardation, long-term planning and actual therapy may well be done on an outpatient basis. So may treatment of the early stages of emotional disturbances in mildly retarded children, with the avoidance of hospitalization a possibility.

An outpatient clinic for the retarded must provide a variety of services. Control of seizures, help with relatively simple child care problems, or assistance with somatic conditions may spell the difference between hospitalization and the continuation of home care.

An outpatient clinic can also help to lessen the length of hospitalization by extending services to patients after discharge. The possibility of the clinic following through with the efforts of the residential program can bring about earlier release.

To carry out this variety of services the outpatient clinic needs a professional team combining the skills of physician, social worker, and psychologist.

As a supplement to both hospital and clinic, a day-hospital program to give outpatients the opportunity for therapies available only within the hospital would make it possible for some retarded children to have the advantages of both hospital and home care. Its counterpart, a day-leave program, could help hospitalized patients to community adjustment. These objectives have not yet been achieved at Pacific.

Admission and Release

Usually when a retarded child is hospitalized the move should not be regarded as a permanent plan but rather as a new phase in his treatment program. The family and the patient, if possible, should know the reasons and purposes of admission and should understand the goals which are to be sought. Since separation is usually traumatic for both child and parents, they should be prepared for this.

Methods of admission have an important bearing on the early adjustment of patients and families. Court commitment seems unnecessary for most cases, and can be an extremely traumatic experience for the parents. Well-timed, voluntary admission, with parental consent and careful protection of civil rights is the best method of entry for most children.

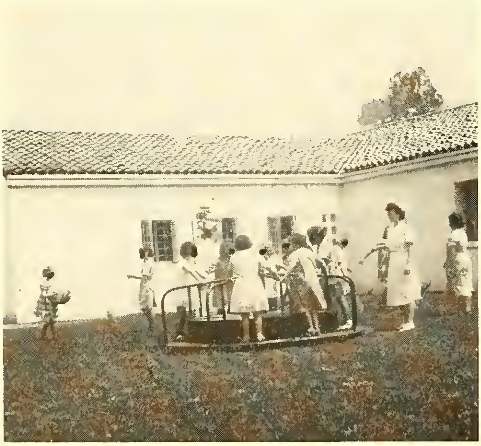
New patients find the hospital a strange environment in spite of the best preparations. A receiving unit, staffed to give intense individual attention, can alleviate anxieties, expedite the final diagnosis and delineate the therapeutic plan. Its staff can also work intensively with members of the family who are disturbed by the impact of separation. At Pacific, where a central receiving unit is under construction, we have found that the period of adjustment usually lasts from 3 weeks to 6 months.

The hospital's responsibility also includes planning opportunities to make release possible and the provision of continued support to help make it a success. To be geared to the needs of the patients, release plans ought to encompass a variety of opportunities—placement at home, in a foster home, or on a job, as the situation warrants.

Developing a foster care program requires considerable skill and effort, but it can be successful. Currently 40 foster homes are caring for patients, of varying degrees of retardation, from the Pacific State Hospital. Each cares for from 4 to 6 patients, carefully selected, with two criteria uppermost: the parents' readiness to accept foster home placement for their child; and the child's ability to benefit. Needless to say, such a program requires continued supervision and work with foster parents to see that the children get opportunities for play and stimulation.

A hospital's release and follow-up plans might be developed with the aid of an outpatient clinic or special staff assigned to community work. Job-finding, foster-home-finding, and follow-up supervision for the patients of the Pacific State Hospital are carried out by social workers from the Bureau of Social Work in California's State Department of Mental Hygiene.

The children here are riding a self-propelled merry-go round in one of the many small play areas around the ward buildings of Pacific State Hospital. The hospital encourages group relationships among children of similar abilities.



Skills and Knowledge

A good clinical program cannot be maintained without a professional staff keenly interested and skilled in dealing with mental retardation, but not over-specialized in this area. It is important for staff members to have opportunities to keep their professional knowledge broad and up-to-date. An important medium for this, both from the hospital's and the community's point of view, is an all-purpose mental-hygiene clinic or a child-guidance clinic. Since emotional problems and mental retardation are closely related, part-time service in such clinics by the hospital's staff can be rewarding. At Pacific an outpatient mental-hygiene clinic on the grounds of the hospital provides such an opportunity. Affiliations with other institutions might bring similar opportunities to other specialists.[8]

The serious shortage of personnel trained to work with the mentally retarded and the need among professional persons who serve the community at large for better understanding about mental retardation obviously put a responsibility on hospitals for the retarded to participate in the vanguards of professional training. Moreover, student placements within a hospital can have a stimulating effect on the program.

The Pacific State Hospital currently is serving as a setting for field placements for university students in medicine, social work, special education, and hospital administration. Two medical schools have undergraduate students in the institution. Graduate medical students specializing in psychiatry and pediatrics are also working there. Such a use of the institution in professional education may result not only in greater professional understanding but also in greater dissemination in the public at large of information about the needs of the mentally retarded.

Scientific knowledge in mental retardation is still in its infancy. If hospitals for the mentally retarded are to improve their programs they must also become centers of research. Their case material lends itself to a multitude of investigations, from methods of diagnosis or studies of etiology to problems in therapy. Furthermore, research is one of the best stimuli for professional growth. Its quality improves with administrative support, adequate funds, and the help of a nucleus of good research specialists. Its results may not only broaden knowledge in the field of mental retardation but may also shed light on a variety of medical problems, such as childhood diseases and schizophrenia, as well as on our general understanding of genetics, biochemistry, and other facets of human life.

The Future

All the suggestions made thus far could be incorporated into the traditional structure through which we now care for the person institutionalized because of mental retardation—the large centralized institution drawing patients from many miles around. Questions could be raised, however, about this structure. Is it the best setting for treating mentally retarded patients who must be hospitalized? Would it be better for such patients to be treated in units of general hospitals near or in their home communities?

There is no unqualified answer. There are pluses and minuses in both types of institutions. Smaller units in general hospitals would keep the patient closer to his family and could give more individualized attention. They would have another plus in bringing problems in mental retardation closer to other fields of practice in medicine. In such a setting opportunities for research and training and for university affiliations could also be more easily worked out. At the present time there are no universities in the country whose schools of medicine or social work offer a chair in mental retardation.

On the minus side of the smaller unit is the shortage of personnel with the skills, experience, and willingness to work with the mentally retarded. This makes centralization of professional resources almost a necessity. Researchwise too there is a possible minus in a small setting. With the scattering of patients sufficient case material may not be available in any locale. The larger centralized units can have a more concentrated case material. They can offer a more varied program to patients. They can utilize available human resources better, and the administrative cost is less.

Out of the current increased interest in the mentally retarded will undoubtedly come more and better trained persons willing to work in this field. When this happens institutional programs may develop locally. Then we will probably find that neither type of institution obviates the other—that the variety of children and problems in mental retardation demands both.

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Projects, facilities, money are important and necessary, but people with appropriate skills must be available and *they* constitute that without which there will be no answers to any of the fundamental problems which confront us.

Grover F. Powers, M. D., Department of Pediatrics, Yale University, at the conference of the National Association for Retarded Children, 1953.

In Los Angeles a continuing interagency committee gets good results from . . .

TELLING THE PEOPLE ABOUT FOSTER HOMES

PATRICIA EDWARDS

"THE PEOPLE who come to ask us about being foster parents know much more about their responsibilities than they used to and there are more of them coming in all the time."

This encouraging report and others like it from both public and private agencies were made in Los Angeles recently when the members of the Foster Home Interpretation Committee gathered together to reexamine their goal. This goal had been set by the Child Welfare Division of the Welfare Planning Council, Los Angeles Region, in 1952.

"People must be told about foster homes," decided the Division, "what they are, where the children come from, where agencies fit in—everything. We'll never interest the type of persons we need for foster parents unless they know we're looking for them."

So the Division gathered together 22 persons to serve as a Foster Home Interpretation Committee. They included professional persons and board members from public and private agencies in the fields of adoption, child placement, mental health, day care, public assistance, licensing, and probation. Today the committee also includes a person from the publicity field. A staff member from the Child Welfare Division of the Welfare Planning Council acts as adviser and secretary to the committee; a lay person serves as chairman, and a worker from a public child placing agency serves as vice-chairman. Two interested laymen serve as chairmen of two subcommittees, the Speakers' Bureau and the Publicity Committee.

For this group to achieve results has taken many words, written and spoken, many hours, and many, many discussions—some friendly, some heated, all interesting.

To start with, the committee prepared a small pamphlet entitled "Thank You for Asking" for sending to tentative inquirers giving them general information on the responsibilities of foster parents and a list of the agencies using them. This was a great help to agency staffs later when increased phone inquiries resulted from the committee's publicity. It is still being used with almost no change in its original form. There is reason to believe that by reading it unqualified inquirers tend to eliminate themselves while the qualified are encouraged to further moves.

Next the committee prepared a brief article describing the use and purpose of foster homes. This was sent with the pamphlet to television and radio personalities, newspaper columnists, local magazine editors after personal contact produced any expression of interest. With the help of the Welfare Planning Council, the agencies purchased a film entitled "To Stranger As To Kin," which tells the story of a boy placed in a foster home. Members of the Speakers' Bureau, formed that fall, have shown this film repeatedly and directed subsequent discussions.

Film Showings

Announcements published in neighborhood newspapers brought requests for film showings. So did the hundreds of letters, written by the newly formed publicity committee to churches, service groups, parent-teacher associations and other organizations. Since the committee has no budget these letters were parcelled out to husbands' secretaries, to members with typewriters and to agency staffs. The Welfare Planning Council helped out with postage. This year the committee organized and trained a group of volunteers to follow up the letters with personal phone calls.

Since the film has been shown more than 100 times all over southern California it is now giving signs of wear. Part of this year's program is to interest some philanthropic group or individual in contributing to its replacement or in making a new one.

The film has also been shown to a number of directors of television stations to convey to them the type of interpretation the committee wished them to do. It stimulated two popular television producers to make their own films about foster care and devote their half-hour shows to the subject. The committee watched every inch of each script like a hawk, and was pleased with the finished products and the many intelligent inquiries which resulted. All hands had to fall to, to answer personally the 80 letters and many other inquiries coming immediately after one show. At this writing the actual number of new foster homes which developed is hard to reckon as the showing took place fairly recently; but the interpretation was vast.

In planning its approach to radio and newspaper people the publicity committee made a point of selecting those who give time regularly on their shows to some aspect of community service. Members of a subcommittee did a thorough job of getting in touch with all of these. As a result committee members and foster parents were interviewed on the air and in print accompanied by photographs.

The committee carries on this type of effort regularly, changing the emphasis as need arises. In one interview the program of one agency looking for a special type of foster home may be emphasized; in another a current need of several agencies, such as homes for adolescents, may be featured. More often the whole foster home picture is explained.

One activity which turned out to be too successful was the use of a series of radio spot announcements, sent out to all the stations to be read at station breaks. They produced so many phone calls to the welfare information service that they could not be handled. Most of the inquiries revealed little understanding of the responsibilities inherent in foster care. Realizing then that short announcements are more emotional than interpretive, the committee canceled a plan, already in preparation, for spot television slide announcements.

The Public Welfare Commission, which is responsible in Los Angeles for licensing independent foster homes, has released an attractive pamphlet written with the committee's help. This explains to prospective foster parents the difference between foster homes used by agencies and those independently licensed. The commission has had a representative on the foster home interpretation committee since it began.

With the help of the research department of the Welfare Planning Council, the committee has developed a double chart for agency use indicating each agency's foster home needs. One portion is a permanent record of each agency's function, giving geographic area covered, age range of children accepted, religious denominations served, and other eligibility criteria. The second part is a special needs form, revised every 3 months, in which agencies check the types of homes needed most, whether for certain age groups, race or religion, for the handicapped or for two or more children or in a specific geographical area. Both charts enable the agencies, the Public Welfare Commission and the council's welfare information service to serve an applicant quickly and help eliminate a chain of referrals. They also tell the committee at a glance where the publicity emphasis needs to be.

A Continuing Task

Last year the committee worked out a series of 13 questions and answers embracing the fundamental principles it is trying to get over to the general public. The first question is simply: What is a foster home? Each question carries two answers, one in thumbnail form and one more fully developed and suitable for incorporation in a series of newspaper articles. This self-answered questionnaire is taking the place of the brief article prepared earlier.

The committee's efforts recently received nationwide notice in two widely publicized women's magazines. One, a 3-page picture article, starred a lay member of the publicity committee who so believed in her work that she became a foster mother. Two other national magazines presently preparing articles on foster home care of children have also come to the committee for information.

The foster home interpretation committee has many ideas to work on in the future. At present it is planning to place more emphasis on interpretation of foster day care.

Although the committee members already share a feeling of accomplishment they agree wholeheartedly that their original goal of consistent, continuing interpretation is just as necessary today as in 1952 and will continue to be next year and the year after and the year after that.

What a State-employed groupwork consultant does to promote . . .

RECREATION FOR COLORADO'S CHILDREN

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THE NEED for group experience is as great for children in rural areas as it is for those in urban communities, but the job of providing it is tougher. The handicaps to be overcome in setting up a community program often appear insurmountable to a lay leader without professional help. Many efforts which have relied entirely on volunteer leadership have died "aborning" or shortly thereafter. A good answer to the problem would be for each county to employ a trained groupworker but this is not apt to happen in the immediate future in any State. Rather than wait for the millenium Colorado has taken a practical step to meet the needs at least partially by putting a groupwork consultant on the staff of the Child Welfare Division of the State Department of Public Welfare, whose services are available to rural counties on request.

The consultant, as a social worker, uses whatever method of her profession the situation demands. She spends a great deal of time on community organization. Research too is an integral part of the development of each program, especially in the form of surveys of community resources. In the early stages of her help to a community, the consultant does not make special efforts to set the focus on the individual child's experience in the group, as this can have meaning only after group experiences are available through recreational opportunities.

When the position of groupwork consultant was created in the Division in 1943, the idea was for the consultant to help county child-welfare workers by suggesting group activities for certain children in need of them. However, this proved to be impossible because of the meagerness of groupwork services in the State, except in three large cities.

In the first few years of this position, its incumbent had necessarily to focus her attention on finding out what the recreational needs and resources were in the State. This involved visits to the counties with the district child-welfare workers, conferences with representatives of national agencies sponsoring programs within the State, and professional consultation to two communities conducting recreational surveys.

After the war, however, communities did not want surveys to find out whether or not they needed recreation services for their children. In most places they were taking that for granted. Many returned veterans who had participated in organized recreation programs during the war through the USO, decided they wanted their children to have similar experiences. The groupwork consultant's problem was how to decide which places needed help the most and where she should focus her attention. Her choice of the far corners of the State and the middle mountain region was directed chiefly by the eagerness of the people in these areas for help in getting programs underway.

Lake County

The groupwork consultant's first direct service to a community was in response to a request from Lake County, 2 miles high. In this mountainous county, with a total population of 10,000, mining is the chief occupation. It contains only 2 towns: Leadville, the county seat; and Climax, a "company town" of the Molybdenum Company, which offers a recreation program to its employees.

In January of 1952 Leadville had no supervised recreation program of any kind. Delinquency was running high among the teen-agers, who had no place to congregate after school except in drugstores or beer parlors or on street corners. Someone conceived the idea of hiring a probation officer to work from 9 p. m. till 6 a. m., picking up all the children out on the street during those hours. When the county welfare director heard of this, she went to the county judge to ask him to postpone this move, expressing her confidence that a more constructive plan could be worked out.

Knowing that the Lions Club had been talking about the need for a recreation program for some time, the welfare director suggested that the club call on the services of the State groupwork consultant. Accepting her suggestion the club arranged a public meeting for interested parents and representatives of clubs and organizations, which the consultant was invited to attend.

The groupwork consultant went to Leadville in advance of the meeting and met with the county welfare director to learn how it happened to be called. The two then called on the chairman of the Lions Club to discuss a number of points: what local groups had been invited to send representatives; what followup had been done to find out who was planning to come; what results were hoped for from the evening's meeting; who would be a good chairman for a recreation committee if the representatives asked for one; whether it would be better to elect a permanent committee at the first meeting or to select a temporary group which could call the next meeting and appoint a nominating committee to bring in a carefully considered slate of candidates. The Lions Club chairman agreed that he would "sound out" during the day the persons suggested as possible temporary chairmen so that they might be prepared for possible election. The consultant suggested that if a second meeting were planned, it would be important to bring in the boys and girls from whom the program was being organized.

At the first meeting 78 persons, including a number of parents and representatives of 33 organizations, packed the county court room. The superintendent of one of the local mines was elected as temporary chairman. A poll was taken of the entire group in order to find out what each person or each organization represented really wanted to do about recreation. Not many persons could describe the kind of program they wanted for their children but almost everybody said he wanted something. After much discussion, the group decided to invite the student councils of the junior and senior high school to participate in a subsequent planning meeting.

At this second meeting the group selected members of the recreation board and approved the appointment of chairmen of four committees: finance; publicity; personnel; and program.

Again the groupwork consultant met in advance of the meeting with the temporary chairman, the welfare director and the chairman of the nominating committee to go over the slate for officers and the tentative list of committee chairmen. Together they decided that those who attended the meeting would be invited to divide up into the committees of their choice and that the date of a third meeting at which all committees would meet simultaneously would be set. At the second meeting these goals were accomplished.

Getting Underway

The consensus of the discussions was that the program would provide activities the year round and would require hiring a paid recreation director with both professional training and experience. Since the community had no recreational facilities it needed a person who could not only establish a program but supervise the building of recreation areas.

Before the third meeting the groupworker met previously with the committee chairmen to discuss the functions of each committee. They arrived at the conclusion, for example, that the immediate job of the finance committee was to draw up a budget; and that the job of the publicity committee was twofold: (1) to see that the local newspaper was informed immediately following each meeting; and (2) to provide special notices to parents about the project's developments.

At the general meeting the groupworker went from one committee to the next answering questions and helping each to get started on its particular job.

The personnel committee worked on establishing qualifications for a recreation director. The consultant supplied this committee with sample job descriptions from other towns of similar size and helped the committee to discuss personnel qualifications in relation to the community's particular needs. One prerequisite, the committee decided, would be interest in winter sports because of the long winter season; another would be understanding unions since Leadville is a "union town."

Dressed up for the town's annual Recreation Review, these children give a demonstration of square-dancing, one of the popular activities in Leadville's recreation program.

The program committee needed the most help from the groupwork consultant. Its job was to plan what should be undertaken first when a recreation director was secured. The groupworker saw her task here as tempering a warm, but impractical desire to provide "everything for everybody right away," without killing enthusiasm. With her help the committee was able to separate immediate priorities—programs for teenagers—from long-range planning, looking to eventual service to all age groups.

Meetings were held every 2 weeks for 2 months; some were general meetings; some, simultaneous meetings of all the committees, held in this manner so that the groupworker could be on hand to help each committee. At the general meetings brief committee progress reports to the whole group did much to sustain interest and cooperation.

The general public was kept informed of progress by the local newspaper and by bulletins to parents distributed through the public and parochial schools.

Three months after the first public meeting, the finance committee announced that sufficient money had been secured to employ a director and asked the personnel committee to find one.

In spite of the personnel committee's careful efforts the first director chosen left after one month in Leadville. Instead of being discouraged, the recreation board took this as a learning experience. It added to its criteria for selection a careful inquiry into the attitude of the applicant's wife and children toward moving into a setting isolated much of the year by the impassable condition of the mountain roads.

It took four more months to find a well-qualified person. This man, the present recreation director, started to work on April 1, 1953, and is still on the job. The key to his success has been his ability to recruit and work with volunteers. Under his leadership such facilities as an all-purpose court, for tennis, square-dancing, and ice skating, has been built, lighted and fenced, entirely by volunteer labor, with foremen from one of the mines supervising the job, also as volunteers. An abandoned swimming pool has been rebuilt by volunteer workers. Arts and crafts, drama groups, and dancing classes have been started with leadership drawn from local talent.

Are all the children off the streets after dark in Lake County? Perfection cannot be claimed, but the continuous wandering of children with nothing to do is a thing of the past. There is enough variety in the program to meet the fancies of all kinds of boys and girls—those who want energetic exercise and those who prefer more intimate group activities.

Children with special problems, referred by teachers and by the county welfare director, are given personal attention by the recreation director. A number of boys who dropped out of school are now back, because of his efforts.

Behind the success of this program are the tremendous energies and enthusiasm of the people of Leadville—particularly of the community leaders. From the beginning it has been their program, as it is today, with the professional persons—first the groupwork consultant and then the recreation director—serving only as resources of information and ideas on possible methods and procedures. Lake County's unions have stood solidly behind the recreation program and have devoted many man-hours of volunteer labor.

La Plata County

The most recent development of a year-round, county-wide recreation program has been in La Plata County, located in the southwest corner of Colorado, with its county seat at Durango, where industrial activity has been booming in recent years.

While there has been considerable interest in organizing a recreation program in this county for a number of years, by 1953 this had still not been turned to achievement. That year the President's Council, composed of the presidents of the various service clubs in the county, decided to take steps. It recommended the formation of a county-wide recreation board, the members to be appointed by the County Commissioners, the Durango City Council, and the District School Board.

Through the county welfare director the groupwork consultant had been invited to attend the meeting at which this decision was made. Subsequently, the temporary recreation chairman, appointed at the meeting, asked the groupworker to attend sessions of each of the three bodies which were being asked to appoint members to the recreation board. Each of these groups agreed to make appointments. The result was the establishment of an outstanding board, with a widely esteemed district judge as the chairman.

During the winter and spring of 1954 the committee conducted a concentrated drive for funds. Enough money was secured to pay a director from June 1 to the end of the year. The committee hoped that a successful summer program would demonstrate the worthwhileness of the undertaking and persuade the three bodies of government to budget sufficient funds for a year-round program. With the help of the groupworker the committee wrote a job description for a full-time director of recreation for the county.

However, the uncertainty of the job's continuing after the summer season was an insurmountable handicap for recruitment on the basis of permanent employment. The alternative was to hire someone for the summer only, in order to operate the program as a demonstration. Because no professional recreation director would be likely to take a 2-month job, its earmarked salary of $400 per month was divided between two hometown college boys who had had some experience directing athletics.

One of these codirectors took charge of the recreation program in Durango supervising playground activities in 2 locations in the town; the other toured the county regularly with a "recreation truck," stopping at the 5 next largest population centers. The county supplied the truck which was loaded with equipment for sports and games.

At the end of 2 months organized recreation had come to La Plata County to stay. The county commissioners had heard from many parents about how much their children had enjoyed the activities, the only criticism being that more were needed.

In March last year, a full-time recreation director started to work on a year-round basis. He immediately set out to organize neighborhood committees in the 5 centers where the recreation truck had operated the summer before, as well as in 5 additional communities. These committees divided up the responsibility for supervising certain county-wide projects, such as marbles and jacks tournaments. They also arranged car pools to take children to and from swimming classes conducted at the Durango High School pool, the only swimming pool in the county, and to a weekly movie in Durango with films selected by the county Parent-Teacher Association. The recreation director attends the meetings of these committees to be available for advice.

The success of the program seems assured. This year the county has enjoyed its first winter of supervised recreation activities for children and young people and is looking forward to an expanded program in the summer.

Again the groupworker's part has been chiefly as a catalyst, helping the people of La Plata County to transform their own energies and determination into the kind of program they themselves want for their children. Experience and readily available consultation are providing them with the opportunity of continuing to develop their concepts of what their children need and of seeing and moving to fill the gaps left by an activity-focused program.

The Ute Indians

The State groupwork consultant has been working for the past year and a half with the Southern Ute and Ute Mountain Tribes in La Plata and Montezuma Counties, respectively, the two most southwestern counties in Colorado.

In 1951 these tribes together with the Northern Utes won a suit against the United States Government for lands taken away from them in the middle of the 19th century and were awarded a total of $31,000,000. The Ute Mountain and Southern Ute Tribes decided to set up long-range plans for the use of their money. Each tribe made its own plan. While these varied in detail, basically they were the same. Some of the money was designated as tribal money to be spent for general tribal expenses, following approval by the tribal council; some went for per capita payments; some was reserved for future individual disbursement.

The Consolidated Ute Agency, the branch of the Bureau of Indian Affairs serving these tribes, has a superintendent genuinely concerned with "working himself out of a job" by helping the Utes to assume responsibility for their own affairs. He is therefore concentrating on the development of leadership among both adults and young people.

In January of 1954 the agency's acting welfare director came to the State Child Welfare Division to ask for help from the groupwork consultant in making plans to send children to summer camp.

The groupwork consultant visited the reservation the following week. She attended a joint meeting of the tribal recreation, welfare, and education committees where she was asked to outline summer camp programs and their benefits to children. After some discussion of resident camps where children stay "around the clock," the consultant told about day camps for children who for one reason or another cannot or do not want to go away from home for overnight.

Participants at the meeting asked how much a day camp program would cost at the reservation and how they would go about having one. The consultant promised to meet with the recreation committee on the following day to go into such details.

At this second meeting the question arose as to whether parents would let their children attend a day camp program if one were provided. The consultant agreed to come back to the reservation in a few weeks and to go with members of the recreation committee to the homes of parents whose children were between 6 and 12 years old, an age group usually interested in a day camp program. At these visits enough parents and children responded to the idea of a day camp to warrant going ahead with a plan.

Program Aides

Because a need for activities for older girls became apparent, the groupwork consultant suggested using them as program aides. According to this plan, girls over 15 would be paid for their services; those between 12 and 15 would be given the status of volunteer assistants. In order to help these girls to get ready to work in the day camp program and to create interest in the project, the consultant arranged a 2-day training course at the reservation at which four second-year students specializing in groupwork at the University of Denver School of Social Work taught crafts, games and outdoor campcraft.

The consultant used a short period of each of these 2 days for discussion with the program aides of ways of putting into practice the skills they were learning. She emphasized that their function was to help the children to have a good time and to learn to do new things. She also pointed out that some of the children might not want to take part in games at first but would only come into them after they could see what they were like and that some might sit on the sidelines indefinitely. She explained that the aides' responsibility was to teach and play games with the majority of children and to leave the "stragglers" for the attention of the director of the day camp.

Volunteers of every age take part in a work party renovating an abandoned swimming pool for Leadville's youngsters.

The consultant also explained that it would be far better for a child to do his own craft work, however imperfect, than for a program aide to do it for him. Reminding the girls of how much fun they were having in making things for themselves, she pointed out that an aide's job was to show the children how to make things, not to make things for them.

The five members of the Southern Ute Tribal Council were individually invited to visit the training course in order to observe the kinds of activities that could be taught to the children in the summer if a day camp program were organized.

After this course was given the members of the recreation committee decided a day camp program would be of great benefit to the reservation's children and prepared a written recommendation to this effect for the Tribal Council. This included a request for a budget sufficient to pay a day camp director and 10 program aides. The recommendation was approved and final plans for the summer were completed by the end of May. Because of the importance of the supervisory aspects of the job as well as the need for strengthening community cooperation between the reservation and the town of Ignacio, included in its boundaries, a top-flight social worker was sought as director, and the professor of groupwork at the School of Social Work, University of Denver was secured.

The program opened on June 6 and continued for 8 weeks, with a schedule offering in the morning crafts, games, storytelling or a cook-out in the reservation's park and in the afternoon roller skating in the gym or trips to Durango for swimming or the movies.

In a report on the summer's program, the recreation committee, the director of the program and the groupwork consultant recommended to the Tribal Council that the same program be repeated and expanded next summer with the program director returning. They also recommended that a recreation program be continued during the fall and winter, with the groupwork consultant helping to arrange for volunteer leaders and scheduling activities.

The Council responded by hiring a tribal member as a recreational director trainee, to be trained by the groupwork consultant to carry out the winter program. Together they devised a schedule of activities to interest teen-agers as well as young children, centered in the tribal recreation hall. The Council also exhibited its interest by sending 14 members of the tribe to the National Recreation Congress in Denver and 7 members to the State Conference of Social Work.

The recreation committee hopes that in the not too distant future a full-time, year-round recreation director will be hired by the Tribal Council to supervise programs for all ages. This goal may be reached before the end of this year. At least a continuation of the 2-month day camp program seems assured for this summer. There will probably be senior program aides, those who had experience in 1955, and new junior program aides.

Camping

A large part of the time of the groupwork consultant is concerned with the development of camping for Colorado boys and girls.

Established camps can play an important part in the normal growth and development of the individual child, but the quality of the experience depends on a number of factors, for example: the standards of the camp, the readiness of the child, and whether camping is part of a total, year-round plan for the child or something impulsively "dreamed up" as summer approaches to give parents some "freedom."

The consultant has been working with camps in the past several years on the subject of referrals from social or health agency to camp and camp reports back to the agency. She has talked with child-welfare workers and other county staff about the importance of long-range planning for the camp experience and the use of the camp experience in future planning for the child. The consultant has also been actively participating in the Colorado Camping Association, a section of the American Camping Association, a private, national, standard-setting agency, concerned with raising camp standards.

Other Functions

Another part of the groupwork consultant's job is in assisting children in the more remote parts of the State to go to camp through promoting a program of "camperships." In many parts of Colorado the expense of travel plus a camp fee makes it difficult for parents of limited means to send their children to camp. Generally, the financing of "camperships" has been underwritten by such community groups as service clubs or women's groups.

At this writing plans are being completed with local committees in seven counties for a volunteer leaders' training course for leaders of all kinds of groups: church, 4–H, Girl Scout, Camp Fire, Cub Scout, Farmers Union, Consumers Cooperative and others. The courses are being established by the groupwork consultant in cooperation with the Extension Service of the State Agricultural College, as well as the county agents and home demonstration agents in each of the seven counties. However, the real planning, including the selection of subjects to be taught and the publicity and registration involved, is being carried on in each county by a representative, countywide committee.

The main job of the groupwork consultant in the Child Welfare Division of the Colorado Welfare Department is a "helping" job—to take consultant service on recreation and group activities for children and youth to the counties requesting assistance, through their local welfare departments, district supervisors of the State Welfare Department, and child welfare consultants. It is primarily a community organization job, with emphasis on providing fun and group experiences for children in rural areas who might otherwise be deprived of the joy of learning new skills and playing together.

THE CONSISTENCY OF CULTURE

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IT IS REFRESHING to read a book on culture and children without feeling the need to gather one's strength to withstand the impact. There is in "Childhood in Contemporary Cultures"[1] no hidden muck-raking of American culture; and the descriptions of child-rearing practices outside of this country do not provoke the familiar feelings of insecurity and guilt, the conviction that we have failed our children because we have not brought them up as the Balinese bring up theirs. In fact, what the book reveals is that only the Balinese, who feel and think as Balinese, can bring up children in a Balinese way; it is not a matter of following a formula, or of applying techniques; and in the end, the result is someone who feels and perceives and acts and structures experience as a Balinese, not an American.

So this is a book which raises questions leading to further inquiry, but does not raise doubts. In fact, it is a reassuring book, a clarifying book, for those of us who have been shaken and confused by some of the literature on this subject. It is a book which will help us recognize implicit assumptions in our culture, will lead us to examine them, but so as to understand them rather than to weigh them against the assumptions of other cultures.

What distinguishes this collection of writings is the stress on the underlying consistency of culture; the way a mother treats her child, a teacher shows a toddler how to dance, a boy completes a story, are presented as consistent with all the other aspects of the culture. An American mother reading this collection can see the German child expressing in his story completion reflections of child-rearing literature his mother reads, the juvenile fiction he reads, his mother's rearing, and his own participation in the entire German culture. Or when she reads of the French mother with her clean, quiet children in the park, creating a wall of isolation separating her children from all the others, and sitting beside them remote and uninvolved, she may feel glad that she is an American mother, enjoying her child's exuberance, his casual relations with new playmates; able to watch undisturbed while her child accumulates dirt. Yet she will see, also, how right it is for the French mothers to act and feel differently, since in this way they somehow help their children grow into French adults, secure in their parenthood, assured of their knowledge and wisdom, enjoying their adulthood, happy to stay at home nights.

If we have a lingering regret for the golden age of child-rearing, we learn here that we shall at any rate have to go back beyond 1820 to find it, if it was ever present in our culture. An article analyzing the American literature on child-rearing between 1820 and 1860 speaks about the many mothers' clubs in which such subjects as "breaking the will" (eminently desirable) were discussed. Even then the literature had to urge mothers to breast-feed their children. It also advised early toilet training, and an unwavering emphasis on cleanliness: "for dirt and indelicacy are frequent companions." This was a time when many children were quieted with drugs; in 1837–38, inquests showed that almost a third of the deaths due to opium were those of infants.

A Common Theme

That was certainly not a golden age; and Martha Wolfenstein's analysis of the different revisions and new editions since 1914 of "Infant Care," bulletin of the Children's Bureau, shows that these document continuing change, perhaps development, in child rearing. Yet the theme of her paper, Fun Morality, does not allow us to feel smug. True, we have come a long way even since the time when a child's impulses had to be curbed, and when his only needs were physical. But—have we substituted the reverse? Is fun itself now a moral imperative?

The volume offers great variety. Indeed Margaret Mead states its purpose is "to give the student and interested reader some idea of the kinds of research which may fruitfully be explored from the standpoint both of method and of results." Yet there is one common theme; all the papers deal with the question of how an individual comes to grow into the representative of one particular culture; how a baby grows to be a Balinese adult, and not a German or an American.

The papers vary in methodology and focus. One culture, such as the French, is studied at different points: an analysis of films to find the cultural image of the child; an analysis of children's drawings; and observation of mothers and children in different situations—in the park and in the psychiatrist's office. There are clinical studies, and content analyses of materials. There are studies based on projective tests, on interviews, or on various approaches in combination.

Variations in Culture

Margaret Mead gives vivid vignettes of remembered scenes; a Balinese child, absorbing the movements of a dance, or darting out of an audience, or responding to a teasing adult. Else Frenkel-Brunswik's paper, "Differential Patterns of Social Outlook and Personality in Family and Children," presents two case studies in the context of not only the immediate family but also of generations of family history. Martha Wolfenstein analyzes films in four cultures to discover their image of the child. And Mark Zborowski points out the factor of community support in becoming a valued adult.

There is great variety of subject matter and approach; yet the theme is common, and, beyond this, the approaches have this in common, that they are all, in the words of Margaret Mead, "studies of pattern, of the stylistic interrelationships of different aspects of childhood . . ."

Conversely, nowhere do we have a study of a segment, or a synthesis of previously dissected segments. The studies may be brief and delimited, but the chosen aspect is always viewed in the context of the whole child and of the whole culture.

Common to all the studies, also, is an implication of variation in culturally structured experience, in kinds of valued adulthood, and in possible, effective ways of arriving at this state. This raises an underlying question: is there only one way, one right and effective way, for achieving specific personal qualities?

We have here a reprinting of Ruth Benedict's article, "Continuities and Discontinuities in Cultural Conditioning," originally published in 1938. Here she points to the continuity present in cultures where, for example, the small game a little boy has bagged with his toy bow and arrow is treated as seriously as the buffalo meat the father has brought; where a child can tease his grandfather as wildly as he is teased; where an individual is considered as seriously responsible in early childhood as in adulthood; or where sexual activity is never presented as wrong but at worst as inappropriate to certain ages or occasions. In this paper, discontinuity of conditioning is presented as, at best, uneconomical.

Yet when we read the papers dealing with French culture, and see the staggering discontinuity between childhood—an almost agonizing preparation for a state and not a state in its own right—and adulthood, we find what? We find parents so secure in the ways they deal with their children that they have the specialists worried, because, confident in their own knowledge and wisdom, they tend to use their physicians and their psychiatrists merely as diagnosticians; we find people who like being adults, who do not seem to find adulthood dreary, or oppressive, or in need of being escaped. In a culture where,

The seriousness for children of learning to imitate their elders is reflected in the faces of the boys in this informal music class in Bali. The Balinese child learns more by exposure to adult performance than by being taught.

In Bali, where there is "a continuity between the ritual and the everyday," children are introduced early to the traumatic events of life through participation in adult ceremony. Here they watch part of a cremation ritual.

in the words of Françoise Dolto, we find "a parental distrust of the young and of their initiative, a parental lack of respect for the personality of their child, his personal ambitions, his judgment, his act of choice . . . ." we find children growing into autonomous adults, into people who are able to form their own opinions, make their own choices, respect their own selves, and can meet at least some situations with personal initiative and enthusiasm. The French mothers observed in the park gave no encouragement to their children to make friends; in fact, they seemed to make their children subtly suspicious of the intentions of the other children; yet we find deep and lasting friendships among the French.

The question is again raised by Colin McPhee in connection with the Balinese, whom, in a music group "the teacher does not seem to teach . . . he merely makes audible the musical idea to be passed on. The rest is up to the pupils . . . No allowance was made here for youth . . . He explains nothing." Some of the children are very young, still no attempt is made to communicate to them, to motivate or interest them. Yet, McPhee says the "system produced swift results."

Zborowski's article raises this question even more forcefully. Here he describes the *kheder*, the school for the youngest children in the *shtetl*, the Jewish community in the small town or village of Eastern Europe. The little boy went to the *kheder* when he was 3, or at most 5. From 8 a. m. to 6 p. m., for 5½ days a week, he sat in a small room, probably on a bench without a back, often in the cold, learning to read and memorize prayer books which he could not understand and was not expected to understand. There were no illustrations to attract and hold his attention; and when his attention wandered he was whipped. His teacher was by definition a failure, a man who taught because he could do nothing else; despised by the community for selling learning which should be given freely. The child's learning had to be acquired through blind obedience to such a man; through imitation and repetition of what the teacher said.

Yet eventually, out of these *kheder*, come the students of the highest institution of learning, the *yeshiva*, where "the general principle . . . is independence and self-reliance," where the students work with "penetration, scholarship, imagination." In the *yeshiva*, though the student concerns himself with age-old materials, he is encouraged to seek for a new interpretation, an original synthesis. "This mental activity combines the pleasures and satisfactions of high scholarship and of high sport." Where, in the dreary, ill-ventilated room, under the tutelage of the poor, gloomy teacher, did the student learn to find pleasure in scholarship? And how did memorizing and slavish imitation eventuate in originality and imagination?

Expression of Pattern

An answer is provided in this book; its theme, in fact, deals indirectly with this question. It is implied in Mead's introductory chapter: "It is important to realize that it is not any single item of child-rearing practice or of culturally patterned child behavior—not the presence or absence of feeding-bottles or slates, . . . which is significant in isolation. It is the way in which all these thousands of items, most of which are shared with other cultures, some of which are shared with all other cultures, are patterned or fitted together to make a whole. Within these patterns children grow up . . ."

The entire culture, the entire range of patterned experience goes into the process of becoming a Balinese, as is illustrated in the section of the three studies of Balinese childhood. Margaret Mead shows how the child's experience in witnessing a ritual play is reinforced in his experience when an adult teases him, and is symbolized in his behavior. She shows how his attitude toward trauma reflects the Balinese basic conception of reality like an "already exposed but undeveloped film," so that there is no sequential, climactic development from event to event, experience to experience; so that traumatization does not lead to an expected result.

Here too Jane Belo remarks that in her own experience with Balinese children's drawings, as well as in the experience of others, there seems to be no development of the artist, but often actually a depletion. This seems to show that where individual life and reality in general are phrased as nonclimactic, achievement itself may show no climactic development. On the other hand, the continuity between the ritual and the everyday, the exposed script and its development in actual life, is clearly expressed in the children's drawings.

The answer to our question, then, is that no one trait can be singled out as causative, and, in fact, nothing is at any time solely a cause. Margaret Mead finds in Balinese culture "a perfect expression of the historical nature of culture, in which any separation between cause and effect, any attempt to turn either childhood experience or adult ritual into the cause, one of the other, is seen to be a hopeless endeavor. The two recur together at every stage. . . ." This may be said of any culture. The "cause" is being affected by its own effect, and they are both reflecting, and being supported by, the entire culture. In fact, they may not be cause and effect at all except in the mind of the investigator, or they may be accorded erroneous significance.

In the light of this volume, it seems possible that it is not the continuity or discontinuity in cultural conditioning that is ultimately the significant factor in a child's development, but rather how these function in the culture. Dolto's article, for instance, indicates that the presence of discontinuity has a completely different significance in the development of the American individual and the French individual.

In American society, as Dolto sees it, childhood is a golden age: the child is ideally protected from all traumatization, is allowed full gratification, full freedom from oppressive responsibility, and particularly from responsibility for the consequences of his actions. Adulthood is the time when the assumption of dreary duties and burdensome responsibilities can no longer be put off. In France, childhood is the dreary age, the time when pleasure must be denied for the sake of preparing, with pain and effort, for the golden future of adulthood. Here also responsible participation in the affairs of the group is withheld from the child, not to protect him from something unpleasant, but rather because he must earn the right to this prerogative of adulthood. Adult ways are forbidden joys, and adulthood itself must be deserved through arduous development and training, through long hours of schoolwork, through obedience, and self-denial, through sheer aging. Actually, neither of these discontinuities can be understood by itself but only in terms of the pattern of which they are an expression.

A Transactional Process

To the extent that the subject matter of this volume is a study "of child-rearing practices as a method of analyzing cultures at a distance" it owes its inauguration to a paper written by Geoffrey Gorer in 1941. The twelve postulates he stated then as the basis for his approach are reproduced here, early in the volume. Their inclusion shows the measure of growth in our study of culture in the 13 years that elapsed before Margaret Mead wrote the last chapter of this volume. In stating these postulates Gorer speaks of the "treatment which the infant undergoes" as "molding" adult behavior. There are specified causes here resulting in single effects, differential rewards and punishments establishing habits, and modifications of innate drives which are "imposed" by the adults of society.

After 13 years Margaret Mead writes in the last chapter, "Implications of Insight—II":

"We have realized that . . . the whole familial process was a transactional one. Gradually also our thinking about the way in which character was formed expanded from the immediate influences of parents face to face with an intractable organism, to a realization that these parents were themselves part of a large wholes. . . . (We have) come to realize . . . the extent to which the whole culture and the whole society must be taken into account."

Thus she presents the process not in terms of unilinear causality, but as transactional, a process in which the "rejecting baby" may be as real as a "rejecting mother" with the response system of each suffering, regardless of whether one was an infant and the other an adult.

And so, if we are tempted to take credit for the adults we as mothers produce or to indulge in the mortification of failure, we do not find much encouragement here. Child rearing goes beyond the mother's range of influence, and growth draws on more than child-rearing practices.

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[1] Mead, Margaret and Wolfenstein, Martha, editors: Childhood in contemporary cultures. Chicago: University of Chicago Press, 1955. 473 pp. $7.50.

BOOK NOTES

TALKING WITH PATIENTS. Brian Bird. J. B. Lippincott Co., Philadelphia. 1955. 154 pp. $3.

Even an infant can get some meaning out of the doctor's voice, though he may not understand the words, according to this book. In the half devoted to ways of dealing with children, the author, an associate professor of psychiatry at Western Reserve University, addresses his suggestions to doctors who chiefly treat adults and therefore "may find talking to a child a frustrating and confusing experience." Noting the importance of enlisting the parents' cooperation, he offers suggestions on how the doctor, by actions and words, can help them to help their child.

CEREBRAL PALSY; advances in understanding and care. Viola E. Caldwell. Foreword by Leonard W. Mayo. Association for the Aid of Crippled Children, New York. 1956. 625 pp. $4.

Addressed to professionals of the various disciplines concerned with cerebral palsy, this book according to the foreword, aims "to integrate the opinions of experts from every discipline involved and bring together the several and various parts of a total community plan of treatment and prevention." It is divided into three parts: (1) "Medical Background and Diagnosis of Cerebral Palsy," (2) "The Individual With Cerebral Palsy and His Total Rehabilitation," and (3) "Community Aspects of Cerebral Palsy." More than 900 references are included. An appendix lists selected sources of therapeutic equipment and of films for loan and organizations concerned with cerebral palsy.

COUNSELING IN MEDICAL GENETICS. Sheldon C. Reed. W. B. Saunders Co., Philadelphia. 1955. 268 pp. $4.

Planned to help physicians answer patients' questions about heredity, this book, written by the director of the University of Minnesota's Dight Institute for Human Genetics, presents information on such subjects as twinning, consanguineous marriages, disputed paternity, skin color, the Rh factor, mental retardation, clubfoot, and body sizes and shapes. The author illustrates his philosophy and methods of counseling by reporting his answers to typical questions.

MENTAL HEALTH AND INFANT DEVELOPMENT; proceedings of the international seminar held by the World Federation for Mental Health at Chichester, England. Edited by Kenneth Soddy. Basic Books, New York. 1956. Vol. 1, Papers and Discussions, 308 pp., $4.50. Vol. 2, Case Histories, 289 pp. $4.50.

A 3-week interdisciplinary seminar, attended by 51 persons—mostly WHO fellows—which met in 1952 to study family life in a baby's first 2 years, is reported on in these two volumes. The first volume contains condensations of 35 lectures given by faculty members and summaries of the ensuing discussions. Disciplines represented by the faculty included anthropology, child psychiatry, education, pediatrics, psychology, public-health medicine, and public-health nursing. The second volume presents 13 case histories of American, French, and British children and families.

1,000,000 DELINQUENTS. Benjamin Fine. World Publishing Co., Cleveland and New York. 1955. 377 pp. $4.

The education editor of the New York Times presents a picture of juvenile delinquency in the United States, based on interviews with boys and girls in trouble, on questionnaires answered by school superintendents, college officials, psychologists, psychiatrists, social workers, judges, and others, and on Government and other reports. He also presents tabulated answers given by about 900 young people in State training schools to questions concerning their school and home experiences before commitment and their hopes for the future.

In a chapter commenting on the study Douglas MacNeil, Chief of the Bureau of Community Services in New Jersey's State Department of Institutions and Agencies, urges that community facilities and skills to help in personality development be made available promptly through teamwork among agencies on both the practice and policy levels.

SOCIAL CASE-WORK IN GREAT BRITAIN. Edited by Cherry Morris. Whiteside, Inc., and William Morrow & Co., New York. 1955. 231 pp. $4.

The specialists' papers making up this symposium analyze British social casework practice in various fields, including care for homeless children; work in child-guidance clinics and mental hospitals, with families, with the sick, with unmarried mothers and other persons in sex difficulties; and probation work. While only a few pages are devoted to a discussion of training, since according to the editor "this demands a separate volume," the appendix lists training facilities.

HEALTH, CULTURE, AND COMMUNITY; case studies of public reactions to health programs. Edited by Benjamin D. Paul, with the collaboration of Walter B. Miller. Foreword by Hugh R. Leavell. Russell Sage Foundation, New York. 1955. 493 pp. $5.

Public-health conditions in widely varying communities and efforts to improve them are described in these 16 papers collected by a social anthropologist. The communities are located in Asia; Africa; a Pacific island; and North, South, and Central America. Among the problems faced by health and social-science teams were the need for diphtheria immunization of the children in a group of Thai hamlets, and for the reduction of an infant mortality rate of 276 per thousand live births in a Zululand village.

The papers indicate that success in improving a community's health depends largely on understanding the customs and traditions of the people concerned. For example, a team surveying local health needs in a town in the United States found that "the survey . . . was successful where it ran with the grain of existing traditions and social conventions, and unsuccessful where it ran against the grain."

PROJECTS AND PROGRESS

Child Care

Lack of suitable care for children is one of the most serious problems encountered in California's efforts to encourage self-support by families receiving assistance under the aid to needy children program (California's equivalent of aid to dependent children), according to a study recently completed by the University of California. This was based largely on reports from field representatives and field review teams of the State Department of Social Welfare, statistical data from the Department's Bureau of Social Research, and interviews with private family and children's agencies.

After its legislature eased eligibility requirements for ANC in 1949 the State experienced a sharp spurt in the number of families receiving aid, and the costs of the program rose. As a result, the 1951 legislature placed a number of restrictions on eligibility, including one that reads, "Children may be disqualified for assistance if their parents refuse to accept reasonable employment or vocational rehabilitative training." The legislature also specified that the law was to be "administered in such a way that needy children and their parents will be encouraged and inspired to assist in their own maintenance."

The State Department of Social Welfare, which administers the ANC program through the 58 counties, at once issued new regulations, urging that the counties, in deciding on eligibility for aid, consider each family's individual circumstances with regard to arrangements for adequate child care, the mother's health and strength, and the availability of reasonable work. Also, as a step toward assisting mothers to find suitable work, the department worked out agreements with State employment and vocational rehabilitation agencies, with business firms, trade associations, and other possible sources of jobs.

However, according to the study report, application of the self-support policy to families was handicapped by the fact that the local offices concerned were insufficiently staffed to handle the additional cases. Employment and rehabilitation workers found that placing mothers applying for aid took three times the effort necessary to place other jobseekers, because of several lacks—employment opportunities, skills, language facility, transportation, and telephones—and their need for unusual work hours because of child-care responsibilities. County welfare departments found that staff shortages and lack of trained social workers kept them from giving each family's needs careful consideration. Some counties misunderstood or ignored the State policy on child care, the report says, and many case records showed inadequate planning for supervision of children. Many counties, however, carried on the program wisely and humanely, according to the report.

In general, the study found that the California experience points up the necessity for specialized social-work skills in carrying any policy aimed at lessening dependency. In this program, the report says, the primary need is planning for child care, because children in broken homes have greater psychological needs than most other children. It points out that payment of aid to needy children is an investment in the future. It warns that although the self-support policy may accomplish immediate savings in program costs, such savings may be at the expense of social losses to the community which can result in further expenditures of public moneys.

Copies of the report, "Self-Support in Aid to Dependent Children; the California experience," by Margaret Greenfield, are available for $2 from the Bureau of Public Administration, University of California, Berkeley.

Adoption

Within 2 months after a campaign was begun in Milwaukee County, Wis., to find boarding and adoptive homes for Negro children, four local child-placing agencies received 87 offers from families to take a Negro child—at least 4 times as many applications as the agencies normally receive in 6 months. Eight of these families looked forward to adoption.

The campaign, carried on by an interracial committee appointed by the child-welfare division of the county's community welfare council, built its plans on the theory that if the Negro community understood better the needs of children for homes and knew more about the agencies' policies and procedures, more couples would be seeking children.

Accordingly, the committee met with more than 100 Negro leaders—clergymen, doctors, lawyers, and heads of civic and community organizations—and planned with them to hold a number of small meetings, at which speakers selected by the committee would answer questions about child placement and discuss with the group the needs of Negro children for homes. The committee provided the speakers with kits of informative materials.

The council reports that in October 1954, before the campaign began, the four agencies were caring for 40 Negro children for whom no homes had been found. But a year later, in October 1955, 1 agency alone had 32 unfulfilled requests for Negro children.

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The Russell Sage Foundation is financing a study of independent adoptions, to be made by the Florida Department of Public Welfare with research guidance by the Children's Bureau. In Florida, as in the majority of States today, the adoption law requires social investigation of independent placements at the time of legal adoption. The purpose of the present study is to evaluate the effectiveness of such investigations, to inquire what determinable factors seem to be associated with successful and unsuccessful adoptions and to secure information that might contribute to more effective safeguards for parents and children in adoption.

The findings will serve as a guide in determining future procedures in the administration of the Florida adoption law, in planning for better provision of adoption services and in determining policies and procedures if it is decided that the Department will initiate a state-wide adoption placement service.

The Florida department points out that this is a study of independent adoptions and that any comparison with agency placements would require other studies, made in other States where it would be possible to secure a more representative sample of agency adoptions.

The study will be conducted by an interdisciplinary staff, including caseworkers experienced in interviewing and in evaluating parent-child relationships and social scientists experienced in psychological testing and in research.

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The Children's Bureau is cooperating with the Elizabeth McCormick Memorial fund in developing plans for a study of medical services for unmarried mothers. The question particularly under consideration is whether the need for payment of medical care is an important factor in influencing girls to place their infants for adoption "independently." Other explanations of why many girls do not use the services of social agencies in helping to arrange placements will also be explored. Planning for the study is being financed by the Field Foundation.

Child Protection

Legal action concerning children and families should be carried on in one court in each geographic area, and that court should be of major stature and provided with adequate auxiliary services, according to recommendations made recently by the New York Legislature's Temporary Commission on the Courts.

The Commission's report points to the fact that in New York State family problems may find their way to any of 10 different courts and that few of these have auxiliary services such as a probation department and social and psychiatric services. The commission notes that the court now making decisions on the custody of children is one of those without auxiliary services.

In regard to the need of a family court with high stature, the Commission says: "In New York State the domestic-relations and children's courts, which handle most of the matters that should be in a family court, are inferior courts, not of record. Often the adjudications of these inferior courts do not determine the basic issues and therefore cannot be fully enforced."

The report suggests that a basic weakness in the procedures in these two courts arises out of lack of delineation between the duties of the judge and those of the social staff. It recommends that procedures of the new family court be regulated by legislation.

Among the responsibilities which belong in a family court the report names: marital actions, including child custody; delinquent and neglected children; adoption; and support of children, including those born out of wedlock.

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In June 1954, 5,149 persons were employed full time in professional positions in the child-welfare programs of State and local public-welfare agencies—a 4-percent increase since the previous June. Seventy percent of these workers were paid entirely from State and local funds and 30 percent were paid wholly or partly from Federal funds.

At the same time 54 percent of the counties in the United States—where three-fourths of the Nation's children lived—had available the services of at least 1 full-time public child-welfare worker, as compared to 52 percent the previous June. However, only 19 percent of the counties in June 1954 had the services of at least 1 public child-welfare worker per 10,000 child population.

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As a step toward protecting children in time of emergency, Sweden's Save the Children Association is carrying out a campaign for distribution of identity disks, as recommended by the 1949 Geneva convention on the protection of the civilian population in time of war. In Belgium a royal decree last December ordered that disks be provided for all children under 12 years of age.

Child Health

About 8,700 American Indian children will eventually be reached by a 3-year project to combat tuberculosis recently announced by the Public Health Service, United States Department of Health, Education, and Welfare. The agency has contracted with the Phipps Institute of the University of Pennsylvania to work toward prevention and cure of tuberculosis among Indian children in New Mexico and Colorado. If the techniques prove successful they will be extended to other areas, according to the announcement.

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To enable more children to receive first and second injections of polio vaccine before the summer polio season begins the Public Health Service recently endorsed the suggestion of several State health departments that physicians postpone for several months giving the third of the three recommended injections. The postponement is recommended only as a temporary measure in view of the current shortage of vaccine. The Public Health Service has pointed out that the final decision as to postponement rests with State and local health departments and private physicians, who can best judge local conditions and the needs of individual patients.

The vaccine available is being distributed among the States on the basis of each State's population of children under 15 and of pregnant women.

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Eight percent more children received physicians' services under the State-Federal crippled children's program in 1954 than in 1953, State reports to the Children's Bureau show. The 1954 total—271,000—continues the upward trend that has been occurring over most of the years since Federal funds were first granted to the States to extend and improve their services for crippled children.

Four-fifths of the children—221,000—received the physicians' services in clinics—an increase of 9 percent over the 1953 figure; 48,000 received them at home or in the doctors' offices—an increase of nearly 13 percent. While these increases in children receiving out-patient care were taking place, decreases were occurring in the proportion of those receiving in-patient care; these decreases continued a long-time downward trend in such care. Hospital in-patient care was provided to about 44,000 children; 4,100 children received convalescent-home care.

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Almost every type of maternal and child health service provided by State and local health departments reached more mothers and children in 1954 than in 1953—a reversal of the trend in several services for the two previous years, according to reports to the Children's Bureau. Decreases occurred in physicians' services to children past infancy and in nursing services to school-age children.

About 187,000 pregnant women received medical services at prenatal clinics during the year, and 263,000, nursing service. After childbirth, 53,000 mothers received medical examinations and 295,000 nursing service. About 442,000 infants were brought to well-child conferences, and 705,000 received nursing service. In the preschool group, 575,000 children attended well-child conferences and 758,000 received nursing service. School children were given 2,626,000 medical examinations and 3,050,000 dental examinations.

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Recent discovery of the basic cause of a disease of infancy called galactosemia promises to lead to a rather simple diagnostic test, making earlier life-saving treatment possible, according to the Public Health Service's National Institute of Arthritic and Metabolic Diseases.

Scientists at the Institute have found that the disease, which in later stages leads to cirrhosis of the liver, mental retardation, blindness due to cataract, and death, is due to the lack of an enzyme, P-Gal transferase, in the infant's system. Without this enzyme the body is unable to utilize or even tolerate milk in any form.

The disease ordinarily appears within a few days after birth. If it is diagnosed in an early stage, the child, placed promptly on a milk-free diet, will grow and develop normally.

Maternity Care

The Ministry of Health of England and Wales recently sent a memorandum to hospital boards and committees pointing out some advantages in keeping newborn babies with their mothers instead of in nurseries. Among these it lists: early establishment of the mother-child relationship; and lessened danger from spreading infection, from the occasional "silent" death (apparently from suffocation) that occurs in nurseries where babies are left alone without constant attention, and from illness due to changes in temperature.

When a new maternity unit is planned the advantages of rooming-in should be kept in mind, the memorandum suggested, maintaining that no more space would be required, but only some reallocation of present accommodations. Recognizing that some babies must be kept in nurseries, the Ministry advised that the cribs in these be small in number and widely spaced; that the nursery be near the lying-in ward; that a staff member be constantly on hand.

Here and There

The Interdepartmental Committee on Children and Youth, representing 28 Federal agencies, met at Princeton, N. J., February 26–29, 1956, to consider new directions in community planning for mentally retarded children. The meeting was co-sponsored by the Josiah Macy, Jr., Foundation, which enabled the committee to invite 12 consultants, each with considerable experience in some area of work for the mentally retarded. The discussion focused on research into causes and prevention, developments in educational programs, the possibilities for greatly expanded community services, new approaches in institutional programs, and the training of personnel for services.

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On March 19 the Senate by resolution authorized the Committee on the Judiciary to continue the work of its Subcommittee to Investigate Juvenile Delinquency until January 31, 1957. A digest of information on the subcommittee's work during the first session of the 84th Congress and its plans for the next 11 months appears in the Congressional Record for March 19, 1955.

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Only slight differences in the pattern of home management were found recently in the households of 22 working and 22 nonworking mothers—all wives of employed college students and mothers of two children—in a study made by the Michigan Agricultural Experiment Station. The study showed that husbands of working wives did more food work—planning and preparing meals and washing dishes—than husbands of nonworking wives, and shared more in home laundering. But on the whole responsibility for routine house care fell on the wives, employed or not. How much the husband shared in child care seemed to be an individual matter depending little on whether or not the wife held an outside job.

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The United Nations Department of Economic and Social Affairs early this year brought out the first issue of a new semiannual journal, *International Social Service Review.* It will be devoted to United Nations technical studies, reports of major technical-assistance activities, and similar information. The first issue, dated January 1956, includes four sections: United Nations program for family and child welfare; day-care services for children; home-help services; and selected bibliography on family and child welfare.

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United Community Funds and Councils of America, Inc., is the new name, adopted March 15, 1956, of the former Community Chests and Councils of America, Inc. Its address remains the same: 345 East 46th Street, New York.

Facts and Figures

The number of children under 18 in the United States increased from 47 million in 1950 to 56 million in 1955—an 18-percent rise, according to the Bureau of the Census. During the same period the Nation's population under 21 years of age increased by 16 percent, from about 54 million to 62 million.

Recent population projections by the Bureau of the Census indicate that between 1955 and 1965 the number of children under 18 will rise by about 21 percent, to a total of more than 67 million. In this period the number of children 10 to 17 years old is expected to increase by about 48 percent, as the large number of children born in the late 1940's and early 1950's enter this age group.

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Of the 8,000,900 people receiving benefits in 1956 under the old-age and survivors insurance system provided by the Social Security Act, 1,282,000 are under 18 years of age. Of these, 1,160,000 are children of insured workers who have died, and 122,000 of insured workers who have retired. Also, 293,000 mothers of children under 18 are receiving survivors' benefits.

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Eight percent more delinquency cases were reported to the Children's Bureau by juvenile courts for the calendar year 1954 than for 1953. This represents the sixth consecutive annual increase in reported cases. The Bureau estimates that about 465,000 children between the ages of 10 and 17, or 2.4 percent of the children in the United States of those ages, came to the attention of juvenile courts because of delinquent behavior in 1954.

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Of the estimated narcotic addicts in the United States, 13 percent are less than 21 years of age, according to preliminary findings of a Senate Judiciary subcommittee investigating the traffic in illicit narcotics.

IN THE JOURNALS

Hospitals and Adoption

Hospital authorities have a moral, ethical, social, and legal duty to discourage placement of babies for adoption through anyone other than an agency licensed by the State, says Anne Leatherman in *Texas Hospitals* for February 1956. ("The Hospital's Role in Adoption Proceedings.") She reminds them that when a baby is discharged from the hospital to anyone other than his mother the hospital is required to report this fact to the State Department of Health. The author urges hospital authorities to encourage licensed-agency placements by referring mothers of babies born out of wedlock to a licensed agency, or if there is none in the locality, to the local public welfare office; by explaining the law concerning child placement to anyone who plans to place a child independently; by developing social services in the hospital; and, when necessary, by referring unmarried mothers to licensed maternity homes or other agencies licensed to provide services to unmarried mothers and their babies.

Institutional Orientation

Emotionally disturbed children entering a residential institution usually need help in getting accustomed to their new surroundings, says Robert R. Sucgang in *Federal Probation* for December 1955. ("Orienting New Students in a Residential Treatment Institution.") He describes an orientation program tried in 1954 at an institution for boys 10 to 16 years old which was accepting 10 boys a week.

During the short (1-week) orientation period the new boys lived in their cottages and met mornings and afternoons with a social groupworker, who explained the institution's programs and policies, answered questions, and tried to relieve the boys' anxieties. The groupworker studied the boys during orientation activities which included interviews with staff, discussion meetings, arts and crafts, recreation, and a tour of the grounds and facilities. His observations of attitudes, feelings, and relationships with other boys and with adults, correlated with reports from the cottage parents, psychiatrist, psychologist, and caseworker formed the basis of a preliminary diagnosis and an individualized training and treatment program.

When Housemothers Depart

Reactions of children and staff to the resignation of a key worker in a small institution for disturbed children are described by Jules Schrager in *Social Casework* for March 1956. ("Observations on the Loss of a Housemother.") He points out that an institutionalized child usually has experienced more than one separation already—from his parents and from other persons who have taken care of him—and is likely to interpret a housemother's departure as a continuance of the "loss-restitution-loss cycle" from which he has previously suffered. Other staff members are also often adversely affected when a key person leaves the institution, the author adds, and suggests that techniques be devised for handling the anxieties of the staff, taking into account "intrastaff and child-staff relationships."

The article recommends that institutions try to lessen the now frequent turnover in staff by making the child-care jobs more appealing.

Hostels for Mothers

Low-rent public hostels as temporary residences for working mothers who have been widowed or deserted, or are unmarried, are advocated for India by Dr. G. P. Banerjee in the *Indian Journal of Social Work* (Bombay) for December 1955. ("Hostels for Working Mothers.") A hostel, supervised by a trained social worker, could reduce institutional placements in India and prevent many childhood maladjustments by keeping fatherless children in their own homes with their mothers, the author maintains. Keeping the family atmosphere, the mother could cook morning and evening meals for the children and be with them whenever she is free and they would be fed and supervised in her absence.

As soon as a mother's circumstances permit her to live with her children independently in the community, hostel authorities should encourage her to do so, says Dr. Banerjee.

Training Day-Care Staff

An in-service course for nursery-center personnel is described by Dorothy E. Howland in *Nursing Outlook* for February 1956. ("A Course for Nursery Center Personnel.") After the author found in a survey of the 24 child-care centers in the New Bedford (Mass.) area that some of the centers' staff members needed help in understanding their problems, she established the course with the help of the Division of University Extension of the Massachusetts State Department of Education. Subjects discussed included the organization and functions of preschool programs, the essentials of group-care practices, the management of nursery-center routines, and the philosophy of preschool education and guidance.

The Hard-to-Place

Pioneering social agencies, public and private, have proved that permanent homes can be found for hard-to-place children, but thousands of such children who would benefit from adoption are still in foster care, according to Joseph H. Reid, executive director of the Child Welfare League of America, writing in *Child Welfare* for March 1956. ("Ensuring Adoption for Hard-to-Place Children.") In most communities, agencies do not have sufficient staff to provide the services that getting these children into adoption would require, says Mr. Reid, calling on the social work profession to make their needs known to the public.

On the other hand, he warns agencies against "rushing blindly into placing every older child who is legally available for adoption," pointing out that sometimes a child has been too damaged by experiences in foster care to adapt to adoption without previous treatment for emotional difficulties.

Recognizing some real economic obstacles to home-finding for Negro children, he urges agencies to guard against making physical requirements for homes so rigid that many couples who would make good adoptive parents could not possibly meet them.

READERS' EXCHANGE

SCHERER: *Protective Casework*

Lorena Scherer's article ("Protective Casework Service," CHILDREN, January–February 1953) stresses too much the difference between protective casework and other family casework. For example:

1. Protective casework must ". . . have a measurable service that can be evaluated . . ." Good. But isn't this true of all casework?
2. "The agency also learns from the complaint that the parents have failed to do *anything* (italics mine) to remedy the situation." How can the worker know this until he has had some personal acquaintance with these parents?
3. "The caseworker must begin with specifics, such as: 'We learned . . . that you sometimes don't know what you are doing when you are drinking and whip the children severely with a strap'." Sometimes, yes. But what of the client who cannot at first tolerate criticism, direct or implied, because of her mother's life-long depreciation? The suggested approach also assumes a stereotype of child neglect. What about the mother who loves her children but who is immobilized by anxiety? Or the father who recognizes his wife's mental illness but is confused about taking appropriate action?
4. ". . . the agency tells (the complainant) that service is given only after community standards of care are unmet." Just what are "community standards"? I would suggest that the worker often needs to interpret to the community what damages and what does not damage children.
5. "The object of protective casework is the child, but the focus is on the parent . . ." There are many instances in which direct treatment of both parent and child is indicated.
6. ". . . the focus of treatment is on the parent part of the person." While the focus should be the welfare of the child, the treatment itself—as in all casework—has to be determined by what the situation demands. In one case it may mean relieving an inadequate parent of part of his burden, and in another treatment of a neurosis.

I agree with the author's general delineation. Protective casework may in part be characterized by the fact that the presenting problem is one of child neglect; that its applications usually come from a secondary source; that the agency has the responsibility to initiate the service and to use its inherent professional authority when necessary. It may be further characterized by the agency's willingness to be aggressive in behalf of the client—by making an exhaustive search for community resources and, where necessary, prodding other agencies to fulfill their stated function when the question has a bearing on the client's welfare.

It should, however, be added that in many instances the only really distinguishing feature of protective casework is the process of reaching the client in an effort to find that point at which he can be mobilized.

G. Lewis Penner
Executive Director, Juvenile Protective Association of Chicago

Realistic casework

Miss Scherer's concepts of the process of protective services are clearly and pointedly defined in her article. However, I should like to comment on her statement that "nearly all parents want to be good parents." This is a concept which needs an explanation derived from the psychological processes of human behavior before it can be a reasonable basis on which to develop a protective casework service.

Any statement which implies, that with few exceptions, physical parenthood engenders necessary emotional qualities, neglects to say that this is so only in those parents who are capable of achieving some degree of emotional maturity with which to carry it.

The wish to be a good parent is often a response to cultural patterns. Its depth can only be measured and valued by the individual's own recognition of his psychological capacity and readiness for parenthood. In the parent whose emotional immaturity drives him to satisfy his own needs before his children's the wish to conform to what society demands is in conflict with psychological inability to do so. The only help the social worker can truly give to such a parent is to help him to know this and to present to him the standards of care below which the community cannot allow a child to live so that he can determine for himself whether or not he is able to meet them. His decision comes when he realizes that the worker accepts his right to decide.

If a parent gives evidence that he not only wants but has capacity to begin immediately to improve the care he gives his family, the caseworker offers to help him for a limited time so that he can prove to himself and the community what he can do. If, however, he recognizes that these minimum standards are beyond him then the worker offers to help in the psychological problems which the family must face in separating from the children. That this may be along with court action is not only probable, but necessary, in most cases.

After the placement, the family is in greater need than ever for help. With the worker holding to what Miss Scherer calls the "core of positives" within a parent, the parent must either face the fact that this separation will be lasting or reorganize himself around the purposes of family living so that the children can return to him.

Marion L. Sheridan,
Supervisor of Special Services, Child Care Division, Pennsylvania Department of Welfare

A clear definition

Miss Scherer's article is evidence that practitioners in the child protective field have defined their methods and that there is a measurable service which can be evaluated qualitatively and quantitatively. In clearly defining goals and methods it distinguishes protective casework from the function of family casework agencies which do not administer a child protective program. This is especially fortunate and timely because of the present interest in "aggressive casework" which in some places has been thought of as the same as protective casework.

Choice of words sometimes leads to misunderstandings. I think it would express Miss Scherer's philosophy (and mine, too) better to say the protective agency focus is on what is happening to the child and that treatment of the parent is essential in order to help the child—also, that in some situations direct treatment of the child is carried out by the protective caseworker. I think it fair to say that, while the worker must identify with the child and his needs, he must also see the parent as a person and help him meet his needs as he is helped to be an adequate parent, for in most situations only as this happens can we help the child. This, as Miss Scherer indicates, carries out the caseworker's goal to help the parent become more responsible.

Those of us engaged in administering child protective services are aware that many of our colleagues in casework have questioned the methods of this particular function, which originated in 1875 before casework and psychiatry were known. It is good to see the growing literature in our field give evidence of the professional insight and method of its practitioners.

Robert M. Mulford
General Secretary, Massachusetts Society for the Prevention of Cruelty to Children

CUMINGS: *No "baby-sitters"*

Long recognized as a "captive audience," the mothers and fathers in a waiting room of a child-health conference have been subjected to sporadic educational efforts by means of audiovisual aids and short talks "to" the audience. In the experiment at the Mamaroneck Health Center, described by Ruth Cumings, something much better was achieved—interchange of the parents' own experiences and ideas. ("Group Discussion in a Child Health Conference," by Ruth Cumings and associates, CHILDREN, January–February 1956.)

It is interesting that these experimenters observed that "separation" of the mother and child for this purpose was not as great a problem as has been anticipated. The preparation of playroom equipment, the recruitment of additional volunteers, and their supervision by an additional public-health nurse undoubtedly deserves much of the credit for this. The handling of separation of a child from his mother is a challenging one to the inexperienced, especially in a situation in which the children do not have the same length of time to relate to either a new adult or other children as they might in a nursery school. Nevertheless the playroom provides a golden opportunity for the observation of each child's behavior.

It should be emphasized that the provision of a "group experience" for such young children cannot be well managed by the simple expedient of a "caretaker-babysitter" type of person but requires personnel experienced in nursery-school practices. Mothers who have had the benefit of nursery-school experiences might be recruited and utilized to great advantage.

In the Mamaroneck experiment an additional public-health nurse was assigned to the playroom and to responsibility for postclinic conferences. One wonders if it is administratively possible everywhere to follow this staffing pattern of two public-health nurses in a child-health conference. One would also like to know whether the nurse-group leader and the nurse assigned to the playroom rotated their roles so that each participating nurse had an opportunity to learn new technics and to develop relationships inherent in the program.

Lucile Perozzi
Child Health Nursing Consultant, Los Angeles County Department of Health

HOTOPP: *Americans and culture*

On reading the essay-review by Dr. Marion Hotopp ("Cultural Difference and Medical Care," by Lyle Saunders, CHILDREN, November–December 1955) I was struck by the thought that to many people *culture* is what other peoples have but Americans or Anglos do not. I am sure Dr. Hotopp is aware of the cultural demands which affect health practices among Anglos but we seem to take these cultural limitations much too much for granted without studying them in sufficient detail. Perhaps what worries me most is the assumption that the psysicians' notion of health practices will fit into the cultural patterns of all Americans. It seems to me that we do not even know how well American patients follow medical advice and if not, why not?

I would like to rephrase Dr. Hotopp's last paragraph:

A very thorough examination of our present public health programs in terms of the cultural demands and limitations of the people for whom these programs are designed and with regard to the applicability of our present health concepts and approaches will surely help to achieve a more rapid and fuller acceptance of these concepts. Furthermore, this understanding of the cultural setting in which we do our work and the increased knowledge of the details of why people act as they do will make us clearer thinkers and better teachers.

Martin B. Loeb
Community Studies, Inc., Kansas City, Mo.

RABINOWITZ: *Wrong impression*

Although its gives pleasure to find oneself quoted, as befell me with Miss Rabinowitz's excellent article on therapeutic work with socially deprived children ("Socially Deprived Children—I. Therapeutic Work," by Clara Rabinowitz, CHILDREN, January–February 1956), I would like the opportunity of putting my own statement into the clinical setting in which it properly belongs, as far as London is concerned. I am correctly reported as a Londoner and as having made the following informal communication to one of her colleagues: "Therapy for a hungry or grossly deprived child is a bad joke—and the child feels it is being made a fool of. Hungry children must be fed even in a Child Guidance Clinic."

This might easily give the erroneous impression that hungry and/or grossly deprived children are by no means uncommon in my clinic, especially so, within the context of Miss Rabinowitz's article which is on children who are primarily victims of bad economic or sociological circumstances. Therefore, I wish categorically to state, that in the past 10½ years in which I have been in charge of the East London Child Guidance Clinic, I have never had before me a child who was hungry by reason of poverty. Such cases as come our way are the children of feckless and/or pathological parents. The same is true of grossly deprived (other than emotionally so) children.

The social services in London, and no doubt of the whole country, are of an extent as to render such circumstances all but impossible for the children of parents of active goodwill and intelligence above the idiot level. I hasten to add that I write as a child psychiatrist and as a taxpayer overburdened beyond the comprehension or experience of any of my American friends, but with no axe to grind.

Augusta Bonnard
London

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

MAJOR CAUSES OF ILLNESS OF VARIOUS SEVERITIES AND MAJOR CAUSES OF DEATH IN SIX AGE PERIODS. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. No. 440. 1955. 22 pp. 25 cents.

The age groups represented in this study of causes of illness and death are: under 5 years of age; 5–14; 15–24; 25–44; 45–64; and over 64.

TEN IMPORTANT AIDS IN DEALING WITH OUR JUVENILE DELINQUENCY PROBLEM. U. S. Government Printing Office, Division of Public Documents. 2 pp. Free.

An annotated list of 10 Children's Bureau publications on juvenile delinquency is presented in this flier along with an order blank for use of the purchaser.

EXPERIENCES WITH INFANTS IN THE PREPARATION OF HOME ECONOMISTS: report of a conference called by the Children's Bureau and the Office of Education, February 3–5, 1955, Washington, D. C. Department of Health, Education, and Welfare, Children's Bureau and Office of Education. 1956. 27 pp. Single copies available free from the Children's Bureau or the Office of Education.

How students of home economics can be provided with opportunity for experience with infants is discussed in this bulletin by 21 specialists in various fields, including pediatrics, psychiatry, psychology, child development, education, nutrition, home economics, social work, health education, and research. Some suggested types of experience are: visiting in family homes; working with staffs of other agencies; participating in the program of infant laboratories and home-management houses, with varying arrangements. Continual review of plans and adequate professional supervision are considered essential.

GUIDE TO MAKING A SURVEY OF PATIENTS RECEIVING NURSING AND PERSONAL CARE. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. No. 454. 1955. 55 pp. 75 cents.

Offers help to communities and States in surveying various types of institutions with regard to personal and social characteristics of the patients, their physical and mental condition, medical diagnoses, nursing care, patients' activities, attendance by physicians, cost of care, and sources of funds to meet costs.

MOTION PICTURES ON CHILD LIFE; supplement no. 2. Compiled by Inez D. Lohr. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1956. 12 pp. 15 cents.

This second supplement to the original compilation includes annotations to 72 films that have become available since the first supplement came out in 1954.

HOW TO OBTAIN BIRTH CERTIFICATES: table showing where to apply for birth certificates in each State and the cost of securing certified copies thereof together with citations to the statutory provisions relative to delayed registration. Prepared by the Library of Congress, Legislative Reference Service. 84th Congress, 2d Session, Senate Document No. 101. 1956. 6 pp. 10 cents.

Brings up to date the information on obtaining birth certificates given in House Document No. 821, 77th Congress, 2d session.

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Development of Blind Children

Attitudes and the Classroom

Licensing Child Care Agencies

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◀

Two musicians in a day nursery in England, where facilities for the daytime care of children of working mothers are as much in demand as they are here.

On this side of the Atlantic many of the States are strengthening their legal provisions for the licensing of child-care facilities to extend greater protection to children in day care. How in one State three departments of government are working together to put greater meaning and effectiveness into the State licensing law is described in an article on page 135.

◀ *the authors*

Retrolental fibroplasia and its effects on children has been the major focus of Miriam Norris's attention since 1942 when she went to work with Dr. Arlington C. Krause at the eye clinic of the University of Chicago Clinics. She received her training in medical social work at the Simmons College School of Social Work and at the University of Chicago School of Social Service Administration.

Recognition for his studies of and work for children brought Ralph H. Ojemann the 1952 award of merit of the Iowa Association for Mental Health and a 1955 citation of merit for leadership and service from the University of Chicago Alumni Association. He is chairman of the Iowa Commission on Children and Youth and a member of Sigma Xi, national honorary scientific society.

Lola Emerson's article on licensing is the result of group thinking—the group being the other members of the Interdepartmental Committee on Licensing it describes. Since receiving her master's in psychology from the University of Cincinnati, Miss Emerson has had a series of interdisciplinary assignments, the first as director of child guidance at Cincinnati Children's Hospital. In 1943 she went to the West to direct a day nursery in Tacoma, Wash.

Esther Schour, *above*, and Susanne Schulze, *below*, were instructor and supervisor respectively of the course for houseparents their article describes. Both have had wide experience in conducting institutes for social workers, Mrs. Schour under the auspices of the Family Service Association of America and the Child Welfare League of America and Mrs. Schulze for various State welfare conferences, community councils, and individual agencies. Before joining the staff of the Institute for Psychoanalysis Mrs. Schour was with the Jewish Family and Community Service, Chicago, and on the social-work faculty of the University of Illinois. Mrs. Schulze has taught at a number of schools of social work since coming to this country in 1937. She received her Ph. D. from the University of Cologne.

The five authors of the article on the orthopedically handicapped were all at the Bureau for Handicapped Children, New York City Department of Health, when it was written. Dr. Helen M. Wallace, then the Bureau's director, has for the past year been professor of preventive medicine and public health at the New York Medical College. Still at the Bureau are her co-authors: Margaret A. Losty, acting director; Dr. Robert S. Siffert, senior orthopedic consultant, Dr. Jerome S. Tobis, consultant in physical medicine and rehabilitation; Caroline Elledge, chief medical social worker. Next fall Dr. Wallace will be professor of maternal and child health, University of Minnesota School of Public Health.

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A recently completed longitudinal study provides clues on . . .

WHAT AFFECTS BLIND CHILDREN'S DEVELOPMENT

MIRIAM NORRIS, A. M.

Associate Director, Project for Study of Blind Children, Section of Medical Psychology, Department of Medicine, University of Chicago

WHAT IS THE EFFECT of the handicap of blindness on the development of the infant and young child? What real limitations does it impose? Is retrolental fibroplasia only one aspect of a generalized brain defect? How can one evaluate the capacity of the blind child and in particular differentiate between the truly mentally defective child and one whose developmental progress has been disturbed by unfavorable environmental circumstances? Are specialized techniques needed to overcome the handicap? What kinds of services should the community be prepared to offer? These are some of the questions to which, for several years, the Project for the Study of the Development of Preschool Blind Children, at the University of Chicago Clinics, has been trying to find soundly based answers through its multidisciplinary research program.

In the brief space of this article one can do little more than highlight the material to be included in the detailed report of the project. Perhaps the most significant finding of the study is that the development of the blind child with no other major physical handicap can be expected to progress in orderly fashion so that by school age he is functioning well up to the level of his sighted peers. This development, however, takes place only to the extent that overall conditions have been favorable for him. This finding emphasizes the importance of getting skilled service to the parents at the earliest age possible if the child is not to become retarded in his development.

The project resulted initially from the broad approach of Dr. Arlington C. Krause, Professor of Ophthalmology at the University of Chicago Clinics, to the study of the problem of retrolental fibroplasia. The formal phase of the research program covers the 5-year period from August 1949 to August 1954. Actually the conclusions in the study are based on observations over a much longer time.

As early as 1942 doctors at the Clinics called in both psychologist and social worker to study with them every case of a blind child, whatever the diagnosis, and to help them in formulating appropriate plans of social treatment. The increasing number of cases of blindness from retrolental fibroplasia in prematurely born children soon created a problem of such magnitude that systematic research into the social and psychological factors in the child's development became imperative. Since many of these children were retarded in functioning according to

The Chicago project described in this article focused on children blinded by retrolental fibroplasia, but the conclusions it arrives at, apropos these children, point a moral for those who work with children sightless from other causes. Happily, the incidence of blindness due to retrolental fibroplasia, which was high during the life of this project, is now being drastically reduced by controlling the use of oxygen in keeping prematurely born babies alive. Henceforth, there should be some 1,000 fewer babies blinded by this cause among those born each year.

normal developmental standards, Dr. Krause believed that such research was essential first in contributing to an understanding of the nature of the disorder and secondly in providing a basis for treatment of the individual child.

In August 1949 funds from the Field Foundation and the Chicago Community Trust made it possible for a psychologist and social worker, already long familiar with the problems, to devote full time to the project. A second social worker was added in March 1951, through the support of the Tibbetts Foundation and later the Woods Charitable Fund, Inc. A research grant from the Public Health Service, U. S. Department of Health, Education, and Welfare, has also contributed to the project's support.

Principles and Objectives

The extensive preliminary experience of the project staff with children with retrolental fibroplasia provided the basis for formulating the general principles underlying the study. Most important were the following:

1. A longitudinal study with repeated observations of the child at regular intervals would yield the most productive results.
2. Such a study should, if possible, follow the child from the time of the diagnosis of blindness until he was of regular school age.
3. The study would require a teamwork approach involving continued working relationships within the University of Chicago Clinics as well as with key community agencies.
4. Service to parents in accordance with the objectives and methods of the research plan would be a necessary part of the research program.
5. The primary focus would be the overall functioning of the child in relation to his total environment. This would require observations in the home by both psychologist and social worker.
6. The study would be primarily descriptive in nature, with gathering and analyzing observed data as its first step.
7. The study should yield data indicating areas needing further investigation and suggest methods for carrying this out.

The objectives were defined as follows:

1. The primary concern of the psychologist was to establish more accurate developmental norms for blind children, which would provide a sound basis for clinical evaluation of an individual child and for social and educational recommendations for him.
2. The primary concern of the social worker was to gain a better understanding of the total development of the blind child with particular reference to the factors which promote or retard his optimal development.

Obviously there were overlapping areas where both psychologist and social worker could make significant observations.

While the project staff recognized the advantage of methods such as the use of a matched control group and a representative sampling of blind children, there seemed to be no way of achieving these. The staff, therefore, sought other safeguards. Since restricting the study to children known medically to the University Clinics might have introduced unidentifiable biases, a cooperative agreement was reached with the counseling service for blind children in the Illinois Department of Public Welfare by which all known blind children in the Chicago area meeting the established criteria were referred to the project between specified dates.

While it is not certain that this had the effect of bringing all children meeting the criteria to the attention of the project, it is believed that the constant efforts of the State Department of Public Welfare to make its counseling service widely known to hospitals, ophthalmologists, pediatricians, and others, combined with the publicity resulting from Parents' Institutes, were sufficient to produce a situation closely analogous to compulsory registration. Since referral to the project was made only on the consent of the child's physician, eye reports and other relevant medical data about the child could be obtained from the doctor.

Children with normal sight share a merry-go-round with a blind child (in coat and cap) in a day nursery in Chicago.

Experience had demonstrated the importance of seeing the child in the early months of his development, preferably as soon as the fact of blindness became established. Intensive study by the project was therefore limited to children seen at or before 15 months of age. All "educationally blind" children in the Chicago area meeting this requirement and having no other major physical handicap received systematic study and casework service—"educationally blind" being defined as those expected by the referring ophthalmologist to require braille in their education. The psychologist's observations of these children were scheduled at 3-month intervals until the child was 2 years and 6 months of age and at 6-month intervals until age 5. Thereafter the observations were on a yearly basis. This intensive group included 66 children. The qualitative conclusions of the research project are based on the analysis by the psychologist and social worker of the combined data on these children.

A second group of children was followed systematically by the psychologist in order to provide a larger number of test observations at the various ages as well as to give some basis for comparison with the intensively studied group. It included "educationally blind" children who for one reason or another did not meet all the criteria for inclusion in the first group, for example, age first seen or residence in the Chicago area. For this second group the age requirement was raised to include children seen at or before 27 months of age. For these children the referring agency assumed continuing casework responsibility on a cooperative basis. This group included 77 children.

Finally, there was a third group composed of 152 children who did not meet the criteria for either of the above groups but for whom psychological-test observations and related social data were available. These were usually children seen on consultation, many of them at the yearly Institute for Parents held as part of the statewide service for preschool blind children carried on by the Department of Public Welfare. For most of these children only one or two psychological observations were obtained.

For research purposes home visits by the psychologist were usually more productive than office visits. This was the plan usually followed except in the third group.

As a result of this plan of study over 2,500 psychological-test observations of young blind children were available for analysis for the purposes of attaining the first objective: that of gaining a better picture of the developmental patterns of blind children.

The social worker's concern was primarily with understanding the basic factors influencing the child's total development (the second objective) and her work was limited in general to the intensive group. Her role followed no set pattern and was dictated by the research requirements and the needs of the individual cases as they were agreed upon in staff conferences, often with the help of the psychiatric or casework consultant or both. Throughout the study she had close working relationships with the ophthalmologist and the pediatrician, both in regard to individual children and in consideration of larger aspects of the program. Of particular value to the parents was the continuing interest of the ophthalmologist in the progress of the child and the problems they were encountering, long after the diagnosis had been made and when there were no further medical recommendations.

Method of Study

For both psychologist and social workers the basic method, observation of the child in his environment, involved highly subjective aspects of professional judgment-making. Recognizing the dangers in such a plan, they constantly looked critically at both method and findings in an effort to secure disciplined and well-documented evaluations. As the study progressed detailed guides for observation and analysis of data evolved.

The fact that the observations came from two disciplines provided a certain safeguard. Moreover, the fact that the *same* psychologist and the *same* social workers were gathering the data gave consistency to the factors operating in the judgments. Staff conferences and discussions with psychiatric, social-work, and research consultants were invaluable in bringing up points particularly susceptible to bias. Repeated observations over a period of time gave opportunities to test out and verify hypotheses.

The original plan had been to follow all children in both groups in the longitudinal study until age 7 when their school progress and evaluation by the school authorities would serve as a check against the project's predictions. Unfortunately, a decision to shorten the duration of the project made the complete attainment of this objective impossible. However, the school experience of the older children served as partial confirmation.

In the intensively studied group the changes in test

At 2 years and 4 months of age, this little girl does not let her blindness deter her from the kind of activity most children enjoy. Here she is climbing a ladder to a slide.

scores and rating of behavior and individual development in relation to changes in the child's total situation provided a safeguard to subjective judgment. There were added checks in the facts that the final analysis of psychological data was made by a psychologist who had had no direct contact with the children and that the analysis of the social data was based on ratings made independently by the two social workers, from which all items producing significant differences of opinion had previously been eliminated.

Two general methods were used for analyzing the quantitative psychological data from the test observations of the children in the three groups: 1) an item analysis to determine the percentage of success on each item at each age level; 2) rating scales for each child at each age interval plus a summary rating of the child's functioning level as measured by the quantitative test data.

Five-point rating scales were also developed to indicate the social workers' evaluation of the "opportunities for learning" which the children in the intensive group had had and their prediction as to the level of functioning which could be expected from them (Prognostic Scale).

The Opportunities for Learning Scale consists of 16 carefully defined items with a summary item 17 expressing the overall evaluation as follows:

> Extent to which the overall learning situation has been favorable to the child's total development with special reference to the degree of self-motivation, self-reliance, and active interest in the environment. Consider quality of relationships, appropriateness of expectations, opportunities for success (in relation to mother's evaluation of child's accomplishment), type and variety of learning experiences both within the family and the larger community.

The Prognostic Scale rated the child with respect to his degree of independent functioning, orientation, use of capacity, and extent of secondary handicap.

Each child in the intensive group was rated also on "degree of blindness" and "orientation."

Though only children expected by the referring ophthalmologist to require braille in their education were included in the study, there was a wide range of degree of blindness, from children who were totally blind to some who had a considerable degree of useful vision. Each child was, therefore, rated on his degree of functional vision as observed by the staff. "Orientation" was defined in terms of the child's ability to get about freely and independently and to relate himself to his environment.

The rating-scale technique made possible some useful comparisons of relationships between the child's functioning as measured by psychological-test data and the complex interrelated factors in his environment.

Summary of Findings

Data gathered in the 5-year study have contributed substantially to the attainment of the project's objectives and to providing a basis for answering the questions raised at the outset.

Analysis of the quantitative psychological data and school and other experience demonstrates clearly that the development of the blind child who has no other major physical handicap can be expected to follow an orderly progression in which he will be functioning up to the age level of the sighted group by the time he reaches regular school age. Probably even more significant, however, is the evidence from the study of the intensive group, that this orderly development takes place only to the extent that the total learning situation has been favorable for the child.

The extremely wide range in the functioning level of blind children has been noted repeatedly, but comparatively little systematic study has been directed to the difficult problems of identifying factors which determine the development of the individual child and of finding ways in which his capacity can be properly assessed. Equally significant with the wide range in functioning found among different children in the project are the extreme fluctuations in test scores of individual children shown in the data provided by the longitudinal study. Almost without exception these fluctuations are found to be related to factors in the child's overall learning situation. The advantages of such records for an analysis of the factors contributing to the child's development are obvious.

But what then constitutes a learning situation which is favorable for the child's optimal development? Here our experience runs counter to many of the traditional views with which the parent is confronted as he tries to understand confusing and frustrating behavior. At the outset let me stress that we have found that blindness in and of itself is *not* the determining factor in the child's development. Rather, failure on the part of adults to know what to expect of a blind child or how to encourage his optimal development creates the problems.

As basic characteristics of "optimal development" the staff agreed that special attention should be given to the degree of self-motivation, self-reliance, and active interest in the environment displayed by the child. All three were areas that traditionally have been expected to present particular difficulties to the blind child. All three were useful in differentiating children who were doing well from those who were making only limited use of their capacity. "Opportunities for learning" also were considered in terms of their contributing to or delaying the emergence of these qualities.

For purposes of summarizing the staff's evaluation of the nature and quality of the child's experience the detailed Opportunities for Learning rating scale was used, summarized under the following headings: 1) quality of relationships; 2) appropriateness of expectations; 3) opportunities for success (in relation to the mother's evaluation of the child's accomplishment); and 4) type and variety of learning experiences both within the family and within the larger community. These ratings were then compared with the child's rating on intelligence and social-maturity tests and with the other variables being studied.

As with all children, the basic ingredient for encouraging the development of the blind child was found to be the kind of comfortable relationship with his parents wherein parent and child both experience continuing satisfaction and enjoyment. Indeed the child's "psychological" development in the limited sense of the term is dependent upon this type of relationship. Yet in the blind child, who depends on it most, the physical handicap operates against achieving it. This happens not only, or even primarily, because of neurotic elements in the parents' attitudes but because of the realistic problems involved and the lack of sound guidance to give parents confidence in their ability to handle their child constructively.

There is real danger in failing to appreciate the realistic basis for the parents' anxiety or in assuming that problems must be due to some personality defect on their part. Moreover, there is too little recognition of the heavy demands which meeting the child's needs for optimal development imposes on the parents, demands which will tax all their resources of understanding, ingenuity, energy, and emotional stability for extended periods of time.

The blind child seems to be particularly sensitive to the feeling tones of the people around him even though his behavior often does little to suggest this to the inexperienced observer. This paradox highlights the importance of getting skilled counseling help to the parents as soon as the diagnosis of blindness is established so that they can better understand the youngster's often puzzling "lack of response" or

A blind boy and his nursery-school teacher. Even playing with paint can be fun for blind children when they are encouraged to discover its feel and smell and to enjoy the movement of daubing and tracing shapes with the brush.

"withdrawal" and learn how to encourage his reaching out to his environment, first to friendly persons, and through them, as he develops, to the world of things.

This reaching out, which is being increasingly recognized as basic in the development of all children, assumes particular importance in the case of the blind child, the very nature of whose handicap imposes a serious barrier to its achievement. All too frequently his development is tragically warped and restricted because of the tendency to assume that limited functioning is the necessary and inevitable result of his physical handicap. Rather the limitations are the response of the child who has been seriously deprived both of emotional satisfactions and appropriate experiences at the successive levels of his development.

Expectations and Experience

I have purposely avoided the use of the word "stimulation" throughout this discussion because of the connotation which it so frequently carries of "doing something to" the child rather than providing the kinds of opportunities which will motivate him to activity on his own part with encouragement and freedom to develop a mastery of his environment by the use of all his capacities. The children themselves have taught us much about how they learn and, conversely, how often with the best intentions in the world, we get in the way of their learning. Here the detailed records have been invaluable, and will serve to provide a better basis for determining appropriate expectations.

Even recognizing the disadvantages of the pressure which comes from expecting too much of the child, we have come to feel that expecting too little in the early period is more prevalent and that this may be even more damaging to his development. Failure to observe and recognize the signs of readiness in the child's behavior and to capitalize on them by providing maximum opportunity for learning new skills is to place serious obstacles in the way of his orderly development. The inevitable frustration the child experiences is a major factor in creating emotional problems, often of great severity. This vicious circle is extremely difficult to break, whether the child's pattern be one of withdrawal or of more aggressive behavior, such as extreme tantrums.

The existence of inadequate expectations even among highly qualified professional persons was illustrated recently in a meeting of a parents' group. A prominent pediatrician, speaking on the development of normal children, said that most children begin to walk between 12 and 16 months of age but that an even wider age range for beginning could be called "normal." Unfortunately he added the comment that a blind child, however, could not be expected to walk before 2½ years of age. One can only conclude that he was generalizing from a limited experience. We have found that blind children can fit into the same pattern as sighted children and that some will walk at well under a year. Seriously delayed walking is usually only one result of conditions which are unfavorable for the child's progress.

Because of the poor motor development of many blind children we became particularly interested in trying to understand why some of the 4- and 5-year-olds in the intensively studied group were showing so much freedom and skill in their motor development and such a high degree of ability to get about independently and to orient themselves in new situations. These children were in marked contrast to the children whom we came to speak of as the *blind* blind children who showed little freedom or initiative in any area.

We found that the children with good motor ability and orientation had all had "favorable opportunities" for this type of development, as we have come to define such opportunities through the use of the rating scales, while the others had had serious limitations imposed in at least one important area. One can predict with confidence that the children who were able to get about freely will be adults who will travel independently, while we may have grave questions, so far as our present knowledge goes, as to the others. According to our findings, skill in orientation seems to bear little or no relationship to capacity as measured by the psychological tests or degree of vision.

There has been such consistent evidence of the close relationship between the functioning of the blind child and his total life experience that we have been forced to the conclusion that any sound evaluation of his capacity depends upon an intimate knowledge of these interrelated factors. For example, we have repeatedly observed children whose functioning was below normal at the outset but who have improved in this as the parents have been helped to understand the child and meet his needs more adequately. We have also seen extreme, temporary regressions when disrupting family problems have occurred, such as illness in the family, the loss of the father's job, or the birth of a young child who absorbed the mother's attention for a time. To take the child's functioning at such a time as evidence of his capacity is tragic in the extreme.

Thus we have become convinced that retarded functioning in a blind child with no other major physical handicap should be presumed to be directly related to the complex social and environmental factors in his total experience until proven otherwise by intensive study. However valuable the various test instruments can be in the hands of a skillful clinician, they are useful only if regarded merely as guides for observation and tools in the study of the child and his family. There is no easy answer to the problem of differential diagnosis and no substitute for careful study by well-qualified staffs of all aspects of the problem—medical, psychological, and social—over an extended period of time if necessary. Unfortunately such diagnostic services are not available in most communities.

In regard to the basic medical question that started us on the research, the evidence strongly supports the theory that the retarded functioning seen so often in children with retrolental fibroplasia is not the result of a true mental defect but is evidence of extreme deprivation of appropriate experience or of emotional disturbance, or both, which has developed because of misunderstanding of the child's basic needs and failure to provide a favorable learning situation for him.

Counseling Service

Are there then specialized educational techniques which are needed by the blind child in the preschool period? We do not believe that there are in the usual sense of the word, though the matter is by no means as simple as the statement "the blind child is first of all a child" would seem to imply. Further understanding of the blind child will come, we believe, as the best scientific knowledge of the development of *all* children is brought to bear on the study of the individual blind child, against the backdrop of the accumulating scientific knowledge of the developmental patterns of blind children.

One interesting aspect of the study has been the opportunity to work with leaders in the nursery-school field in placing blind children in regular nursery schools. Here the Nursery Committee of the Welfare Council of Metropolitan Chicago gave leadership, first in a study of the possibilities and then in accepting blind children into their own agencies. Substantial financial support from the Chicago Parents of the Blind and other interested groups has made placement in regular nurseries possible for any child ready for it. Through the combined efforts of the project staff and the preschool counseling service of the State Department of Public Welfare more than a hundred children in the Chicago area have enjoyed this experience.

The success of the plan has been found to depend on the continued availability of skilled counseling help both to the parents and to the nursery schools. We believe that such placement has great advantages for blind and sighted children alike when it is part of a long-range plan based on an understanding both of the needs of the individual blind child and what the particular nursery school has to offer. Nursery school without the necessary allied services both to the family and the school has, in our experience, been of doubtful value.

There is increasing recognition of the imperative need for skilled casework service to parents, from the time of diagnosis through the preschool period, by counselors who have understanding of the problems of blind children. Such service should make use of and coordinate all the varied community resources which may be needed. Particular responsibility for leadership in the development of services, we believe, rests upon the medical and allied professions, not only because of their contact with the family at the crucial time of diagnosis but also because of their position at the "growing edge" in extending knowledge and developing sound practices for prevention and treatment in the whole field of child development and mental health.

Development of adequate services depends, however, not only upon training personnel who can put into practice what is already known but upon the extension of research methods and the continued critical observation and evaluation of experience. There is urgent need for research into the problems of the multiply-handicapped blind child and for the development of services for the poorly functioning and the emotionally disturbed children for whom institutionalization is too often the only provision. The difficulty in finding effective ways for treating these severely—and in many cases unnecessarily—handicapped children is a compelling argument for providing the needed preventive services that will enable the parents to meet the total needs of the child at the successive levels of his development. Here our knowledge is far in advance of the application of it to meet the varied needs of individual blind children and their parents.

With mental health as a goal Iowa develops a laboratory for experiments in . . .

CHANGING ATTITUDES IN THE CLASSROOM

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WHEN PHYSICISTS became interested in studying the effects of bombarding atomic nuclei with high-speed particles they found that concentrations of particles of the desired speed were not available and had to be produced. Confronted with the need for facilities for producing an essentially new environmental force whose effects on different kinds of materials could be studied, they developed the "atom-smasher" or cyclotron.

Students of human behavior have a similar problem in studying the effects of various environmental forces suspected of having some relation to mental illness and mental health. Suppose we suspect some environmental pressure and wish to investigate its role in the production of behavior disturbances. We can think of two procedures. We might obtain the cooperation of individuals of known characteristics, subject half of them to the pressures and observe the results. Or we could work with individuals of specified characteristics already under pressure, reduce the pressures for half the group and again observe the results.

The various hypotheses as to the causes of mental illness cover a considerable range. Mental breakdown seems to occur in some individuals with distinctly observable organic defects who are subjected to but few environmental pressures. It also occurs in some individuals, who have few, if any, observable organic defects, but who have suffered environmental pressures.

Many people suspect that dissatisfying human relations—parent-child, teacher-child, person to person—constitute one of the important environmental pressures operating in our culture to produce a significant proportion of emotional disturbances.

Consider, for example, a child who "pushes" to be first to such an extent that this interferes with his home and school activities. He is not happy unless he in front, and he constantly fights for attention and recognition. Among the common ways of dealing with such behavior are to remind the child that he cannot always be first, to make him be last, to scold him, or to send him out of the room or out of the family circle. If he does not "behave himself" after these steps, stronger measures are often employed. If a child in school fights to be first so intensively that his aggression interferes with class activity, the teacher may try to stop this by reprimanding him, making him go to the end of the line, or sending him out of the room.

We know, however, that "striving to be first" may be caused by a feeling of inferiority or inadequacy. Through a series of experiences a child may develop a sense of being less worthy than others, of not belonging to the group, or of being discriminated against. Efforts to be first may be his way of attempting to solve his problem. There are other causes for this behavior, but consideration of the feeling of inadequacy will illustrate our point.

A Noncausal Approach

If a child feels inadequate or discriminated against, scolding, isolation, or other punitive treatment will not help him. The feeling will tend to remain in spite of such measures or even be aggravated because of them. Such methods of dealing with children are adopted by adults who do not look below the surface but take a "noncausal" or "surface" approach. When these measures fail, the frustrated teacher, or parent, may initiate even more vigorous measures, thus adding to the child's strain.

Another way for an adult to react to such behavior would be to take account of the causes—to use a "causal" approach, by trying to eliminate the feeling behind the behavior.

In present American culture many children—and hence the future teachers, parents, citizens—are surrounded with a variety of influences which tend to develop a noncausal or "strain-producing" orientation. Our observations have indicated that a great many parents and teachers tend to deal with children in a punitive or arbitrary way. Moreover, analyses of curricular content show that children are actually taught to adopt a noncausal approach toward others through what they read and study in school.

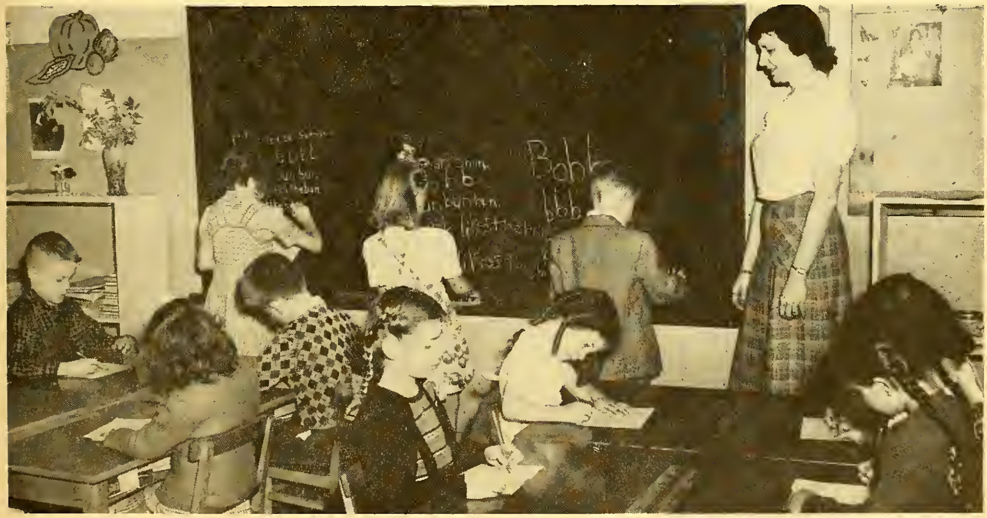
How materials used in teaching children tend to be noncausally oriented can be illustrated by the content of high-school civics materials. The ordinary civics book, for instance, discusses the problem of crime by explaining how the police force is constituted, its legally prescribed functions, methods for detecting and apprehending the criminal, and the system of courts, training schools, and prisons for handling criminals. The fact that some crime is associated with economically underprivileged conditions may be mentioned, but briefly.

Such an approach treats crime primarily as a "surface" phenomenon. If, on the other hand, the curricular material approached criminal behavior causally, the textbooks would raise some questions, such as: Do police and the courts handle criminals in such a way as to determine what caused their behavior? Do they try to find out in each case whether the causes can be eliminated and the criminal restored to society as a self-respecting cooperating citizen? If he cannot be rehabilitated, is the criminal then effectively isolated for society's protection? In other words, does society study the criminal to find the causes for his behavior and then base its treatment of him on those findings? Moreover, in considering what the crime-producing factors are, a causally oriented text would go beyond the observations that poverty and similar conditions are somewhat correlated with crime to ask the more penetrating question: How does it happen that some persons living in a given environment become criminals while other persons living in the same home and same neighborhood do not?

With some exceptions, such questions are not considered in the usual text. The typical treatment is largely surface in character. Similar examples could be cited from discussions of safety, communications, or government.

Therefore if we wish to study the effects of surrounding a child with influences tending to produce more understanding and appreciation of the forces

While learning to write and spell, as are these third-grade pupils, children take in ideas which help to shape their attitudes toward others. The Iowa research is an effort to affect these by changing teacher attitudes and use of curriculum.



that operate in his social environment we will first have to produce such influences. We will have to prepare reading and study materials which treat social behavior fundamentally and realistically, and we will have to develop causally oriented teachers.

In teaching nutrition, a teacher might possibly lay down the principles of nutrition to her class and expect the pupils to apply them in food selection though she secretly violates them in her own diet. But in teaching an approach to human behavior a teacher must of necessity interact with the pupil. The kind of approach she makes to the pupil demonstrates a way of dealing with others which is instructive as well as constructive or destructive. If she works with the pupil without regard to the dynamics of behavior, she demonstrates a noncausal approach and thus teaches her pupils to approach others in this way.

A Laboratory

Therefore, to develop a society sensitive to the causes and consequences of behavior, we need classrooms equipped with teachers deeply appreciative of the forces operating in human development and supplied with causally oriented teaching materials.

Some experimental results indicating the possibility of training teachers in this way were reported in a 1939 study.[1] Programs developed by Daniel A. Prescott and associates for the Commission on Teacher Education [2] and numerous articles, such as those in the yearbook of the Association for Supervision and Curriculum Development,[3] are concerned with training teachers to understand child behavior. But recognition of the essentially noncausal orientation of children and the possibility of producing a causal orientation in them, beginning in the early school years, is of very recent development.

Within the last 5 years some elementary text and reference books have begun to include material touching upon some of the motivating forces in behavior. They represent but a small beginning, however, and practically no tests of the effectiveness of such steps have been made. A really significant approach would require a more thorough incorporation and integration of the causal orientation in the various parts of the school curriculum dealing with human behavior—such as social studies, reading, health, and guidance—and tests of their effects when used by a causally oriented teacher. Such tests require a laboratory for experimentation.

In the Iowa Preventive Psychiatry Research Program we are developing such a laboratory, with financial assistance from the U. S. Public Health Service, the Iowa Mental Health Authority, and the Grant Foundation. Under our general plan the program, by arrangement with a school system, provides summer fellowships so that selected teachers can attend an intensive training program. This program is designed to familiarize the teacher-students with the differences between surface and causal approaches, to help them apply the causal approach to their own behavior, and to develop skill in teaching causally oriented materials.

A supervisor of teachers, on the Preventive Psychiatry staff, works with the teachers throughout the year, holding a series of conferences with each. During the summer training program each teacher assists in the preparation of teaching materials for his own classroom. With the supervisor's help he continues this adaptation of materials for classroom purposes throughout the year. We thus obtain a group of classrooms for our laboratory, each equipped with a causally oriented teacher and appropriate curricular content.

The Procedures

Our program brings up two groups of questions. The first group relates to procedures: How does the plan work? What is the attitude of the teacher toward it? Can teachers be interested in cooperating in such an enterprise? Do the teachers resist training in mental-health principles?

Thus far, we have worked principally with elementary or junior high school teachers. At the present writing we have a group of 13 third-, fourth-, fifth-, and sixth-grade teachers, drawn from two school systems, who have participated in the summer program for 2 years and who have helped to revise various aspects of the curriculum to develop in the child a sensitivity to the causes and consequences of behavior. For instance instead of being content with the usual textbook statement that unlike boundaries between many European countries the United States-Canadian border has never been fortified, they prepared a discussion, based on available studies of conflict and cooperation, on some of the probable underlying factors in producing the United States-Canadian relationships.

The fact that we have had more requests for inclusion in the program than we can accommodate indicates that the teachers on the whole have a positive attitude toward it. Those who have been accepted have cooperated enthusiastically.

Something we learned in our early work may provide a clue to at least part of this cooperation. A change to a causal orientation, we found, requires help in developing understanding in three areas: (1) the effect of past cultural influences on behavior—to enable the teacher to accept herself without excessive guilt as to her past noncausal attitudes; (2) what the emotional needs of children are; and (3) how the feelings of all children can be handled under classroom conditions—the techniques of helping children express their feelings in constructive ways.

While most presentations of mental health for teachers today stress the motivating forces operating in the child, little emphasis is given to the problem of how these forces can be expressed constructively under classroom conditions and how the teacher can accept her past mistakes. One of the hypotheses underlying the approach in our program is that much of the resistance appearing in work with teachers arises from the frustration a teacher feels when she learns about a child's needs but does not see how she can meet them under classroom conditions. In our work with teachers we point out these problems early in the program, on the theory that if the teacher realizes we are aware of her problems and are interested in helping her resolve them she will feel less frustrated. As the program has progressed we have found this to be true. Always we attempt to increase the security and self-respect of each individual member of the program by working with the teachers rather than telling them.

Effects on Children

The questions in the second group are concerned with the effects of the new experiences on children. Can a teacher help children in elementary and secondary schools to take a more understanding approach to social situations? If so, what effect does this have on the children? Does it make them more, or less, secure? More, or less, able to develop satisfying relations with others? We have evidence that significant changes have been produced throughout the primary and intermediate grades. This evidence has been reported in several studies.[4, 5, 6]

A typical example may be found in some of the data obtained from our experiments with the fourth, fifth, and sixth grades. At each level a causally trained teacher was matched with a teacher without such training from a nearby school, who served as a control. The matching was according to sex, age, training, and years of experience. Similarly, the children in the respective classes were equated as to intelligence. The experimental group was like the control group except that the control teacher did not participate in the summer training program and did not use causally oriented curricular materials.

Two Sets of Tests

At the beginning of the school year all the children were given two causal-orientation tests. In one of the tests the child was presented with a series of social situations to which he was asked to suggest a solution. The possible reactions ranged from arbitrary, judgmental, and punitive, such as: "It serves him right—he should be made to stay in"; to an awareness of possible complexity, such as: "The teacher should find out more about this."

In the second test another series of social situations was presented, each followed by a series of statements with which the pupil was asked to indicate agreement or disagreement. Some examples are: "It wouldn't make much difference what method the teacher used to make him stop [bothering others] so long as he stopped bothering others." "Since these boys do the same things [described in the situation] they are probably all alike in most ways." "If another boy disobeyed his father the same way, his reason would be the same as Jack's."

The children were given tests again in the spring and the results of the experimental and control classes compared. In all grades a statistically significant change appeared in the experimental group but not in the control group.

Thus it appears that our laboratory, which consists of a teacher trained to be sensitive to the dynamics of behavior and using a curriculum which incorporates these principles, is producing a degree of causal orientation among children.

How causal orientation affects child behavior may be illustrated by an example. One day a group of children from one of the experimental classes was discussing membership on a committee planning a class trip. The name of one of the "shy" children whom many of the children in the class had disregarded in the past came up. Several of the group suggested that there must be something underlying the shyness, that they were not certain what it was but that they might talk it over with the teacher to see if she could throw more light on this problem before deciding whether membership on the committee would be helpful to this child and to the group.

Does the new orientation help causally oriented children make more satisfying adjustments to their environment? We have various kinds of data to throw light on this question. For example, children from both the experimental and control groups were given the antidemocratic tendency scale test developed by Gough, Harris, Martin, and Edwards.[7] This is essentially a measure of authoritarianism. They were also given the Minnesota "responsibility" test.[8]

A detailed analysis of the results [9] obtained from the experimental and control groups showed a significant difference between the two groups on both scales. The causally oriented children showed significantly less authoritarianism. They also showed to a significant degree more willingness to assume responsibility than the children in the corresponding control classes. It thus appears that as children become more aware of the dynamic complexities of human motivation and behavior their attitudes toward others begin to change from an authoritarian relationship to a more democratic relationship. Also there appears a greater willingness to assume responsibility. In all of the analyses the effects of intelligence were eliminated by various statistical procedures.

There may be several explanations of these results. As the child learns more about people's feelings and the situations they face he may find it easier to accept them and to work with them. Similarly, as the child becomes more at home in his social environment, he may be more willing to assume responsibility.

We hope someday to have sufficient resources for our program to develop a continuous sequence of experiences extending from the early years in the elementary school throughout the secondary school. We need for each grade level a teacher trained in causal principles who teaches a causally oriented curriculum. In the not too distant future we hope to buttress our studies of such causally oriented school experiences with studies of similarly oriented home experiences. This will make it possible for us to find out what happens when the child grows up in a school and home environment subjecting him to causal influences not only for one year but over a period of years. We hope to develop a school in which there are causally oriented administrators and supervisors as well as causally oriented teachers and parents. This will enable us to study the effect of a causal orientation on administrator-teacher relationship as well as on teacher-child and parent-child relations.

A great many questions need answering before we can determine what role a causal orientation in human beings plays in the prevention of mental illness and development of mental health. For example, we want to know what happens in later years to the child oriented causally through his school experiences. We want to know what kinds of behavior disturbances an "inoculation" with a causal orientation will prevent, if any, both during school age and in later years. Already our laboratory enables us to study the relationships that develop between teachers and pupils in the causally-oriented classroom as compared to such relationships in a non-causally oriented classroom. It also points the way for study of a host of questions that arise in the investigations of the causes of emotional breakdowns and the avenues by which mental health in its full measure may be achieved.

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A school should be staffed by people who can stand children, not only understand them.

Howard Lane, Ph. D., Professor of Education, New York University, at the annual meeting of the American Orthopsychiatric Association, 1956.

In the State of Washington three viewpoints on protection merge in a focus on the child through . . .

TEAMWORK IN LICENSING CHILDREN'S AGENCIES

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MUCH HAS BEEN SAID about the value of blending professional skills to effect a team approach in the solution of mutual problems. To talk about such values and recognize their desirability is one thing, to actually accomplish a team approach is often another. In the State of Washington, it proved both difficult and rewarding when three State departments worked over a 3-year period to build a united approach to the development of standards and solution of problems for licensing child-care facilities.

In 1951, a year after a previous licensing act had been declared unconstitutional, the Legislature passed a new law calling for the licensing of child-care agencies, including children's institutions, maternity homes for unwed mothers, and day nurseries. The new law vested the licensing authority in the State Department of Public Assistance, but required prior approval of each facility by the State Fire Marshal and the State Department of Health. Obviously, the three departments had to plan toward integrating their respective responsibilities if the law was to be effective.

Their first problem was to define clearly the division of responsibility in carrying out the licensing law. In administering the new regulations some snags were appearing that could only be unraveled by interdepartmental agreement. Most disturbing of these was the inadequate communication between the departments, which made it possible for substandard agencies to play one State department against another. The State departments needed each other's help in finding the source of difficulty.

Since the three departments, Fire, Health, and Public Assistance, were jointly responsible for carrying out the legislative mandate, it seemed logical to set up some sort of structure for meeting together. Accordingly, the Department of Public Assistance, as the licensing authority, established a committee representative of the three departments. This was composed of: three members from the Department of Public Assistance—the child-welfare supervisor of licensing, serving as chairman, the head of the Children's Unit, and the day-care specialist; three members from the Health Department—the head of the licensing section, a public-health nurse, and a sanitarian; and the Assistant State Fire Marshal.

Certain problems were anticipated and others developed as the committee got down to business in regular monthly sessions. First the members had to arrive at an understanding of the intent of the act. While on the surface this seems clear, the problem nearly brought the committee to a deadlock. The representatives of each department came to the committee with a wealth of information, skill, and experience focused on their own professional values. However, realizing that it must function, the committee proceeded to make mechanical decisions about its structure rather than to wait for a mutual agreement on philosophy and methods.

The members agreed that the representatives from the departments should be the same people at each meeting so that continuity in the committee's work would be assured. The minutes of each meeting, written alternately by representatives of Public Assistance and Health, provided a picture of the growth of the committee's work and were reviewed periodically by the committee for self-evaluation.

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The committee members from the State Department of Public Assistance, as representatives of the licensing authority, prepared the agenda for the meetings using suggestions submitted by the others. The discussion at each meeting of future agenda, involving the reasons for considering each topic and its applicability to the licensing responsibility, became an effective method of forwarding the committee's work. The committee members strove to keep their focus on the child and his needs as the real objective in fulfilling the intent of the legislative act, though they were also aware of the necessity of developing tools for achievement.

The Committee Problems

Each department was charged by law to promulgate regulations for each type of child-care facility to be licensed. The committee had to reach an assurance that those from each department came within its area of responsibility and yet that together they did not leave gaps in protection.

Each department had different working methods and procedures. The State Department of Health and the State Fire Marshal's office were advisory to local health and fire units. Each developed a plan for a working agreement or deputizing a local person to determine an agency's compliance with its standards. The State Department of Public Assistance, having its own offices in each locality as well as a State licensing staff, carried direct responsibility for determining whether or not an agency qualified for a license.

A common understanding of the needs of children, especially those in group facilities, had to be the committee's working base. Before the members could reach this they had to hurdle a number of barriers:

1. Defensiveness. In the beginning defensiveness of the members toward the standards of their own departments caused considerable confusion. Questions about the "why" of particular standards were resented. Gradually the committee members recognized that the resentments arose from assuming that others had more knowledge about the methods and skills of each department than they did. This resulted in a general understanding that such questions were genuine requests for information and that answering them with considerable explanation helped to achieve a common base for working together and supporting each other's standards.

For example there was the question, "Why is zoning related to the fire code?" The question was answered to the satisfaction of the committee members when county and city zoning commissioners, invited to a meeting, explained how both zoning and fire codes were related to land use.

2. Semantic Confusions. Terminology was a stumbling block to mutual understanding. The committee members were talking about the same problems and difficulties, but many of the terms they used conveyed meanings that varied according to the fields they represented. However, as they explained their concepts and the facts behind them to one another they were able to achieve a mutual understanding of basic goals.

For instance, the word "isolation," which was in the regulations for day nurseries, conveyed a variety of concepts.

The public health representatives used this chiefly in connection with controlling communicable disease. The fire department representative saw it in relation to protection from fire hazards. The welfare representatives gave it still another meaning, separation of a child from the group for social, disciplinary, or activity needs.

These varying concepts confused the discussion over the day-nursery rulings until a question about the need for an extra room for separating a sick child focused attention on other possible methods for protecting the health of the group and on other reasons extra space might be needed. With the focus thus shifted from terminology to children's needs, the committee was able to reach agreement that nurseries be required to provide space for separating a child from the group for a variety of reasons—health, rest, removal from stimulation, or other needs. The committee then established principles for protecting health by restricting sick children from admission and requiring their removal from the group.

Overcoming a feeling of having to justify their positions, the committee members worked hard at learning how to present their professional knowledge to each other clearly, concisely, and with substantiating evidence. Each explored his own professional phraseology in an attempt to reach mutually acceptable terms, based on mutual acceptance of child-care standards.

3. Inadequate Mutual Confidence. In the beginning most of the committee members betrayed some mistrust regarding the competency of the specialists in fields other than their own to judge child-care needs—particularly in the areas of overlapping concern, such as rest, food, safe play equipment, and supervision.

However, gradually, by working together on specific questions they were able to develop interdisciplinary confidence and recognition of the limitations of their own discipline's competence. Thus they could achieve a method for transferring responsibility from one specialist to another when an agency problem demanded it. This occurred, for example, in connection with a discussion of total space requirements. The health representatives presented standards of specific square footage for indoor and out-of-door space. The welfare representatives, with knowledge of the methods by which program content could be geared to use space to the best advantage raised the question of whether these standards could be more flexible. Working with each other on this problem not only effected an agreement on several individual agencies but also strengthened interdepartmental relationships.

4. Buck-passing. Since each department had a direct relationship to applicants for licenses, when the act first went into effect some applicants tended to complain against one department to the representative of another and thus to achieve a kind of buck-passing of responsibility among the departments. One agency, for example, resisted the license requirements because of the cost of bringing its building into conformance with fire and health standards. The operator greeted the representatives of each department with stories of having been approved by other representatives in areas outside of their responsibility. Tension resulted in the relationships between all persons involved. The problem was resolved in a meeting of all departmental representatives with the operator. Factual discussion of the questionable areas cleared the channels of responsibility for the operator and by bringing mutual support of the standards strengthened interdepartmental relationships. The operator complied with the standards and received a license.

As they gained knowledge of each other's expectations and of the reasons for them, the committee members were able to work out methods for a more unified approach to agencies. Now, for instance, when an agency has difficulty complying with the licensing requirements the committee discusses the agency problems and plans the sequence in which each department will work with the operator in giving assistance toward compliance with the standards. This produces an orderly plan of work for the agency and necessitates progress reports being exchanged among the departments to keep the licensing process moving toward fulfillment.

As a result of such interdepartmental unity, each department now enjoys better relationships with the agencies in general.

5. Unclear Channels. Many of the difficulties in achieving a unified approach came from obstructions in the lines of communication between the departments. These had to be cleared and modified in some places if applications for licenses were to be processed promptly. Consequently the committee members set to work analyzing and ironing out complexities in the channels of authority. They found that in some areas of the State the representatives of the State Health Department and of the State Fire Marshal worked directly with an agency. In other areas local fire and health departments were deputized to carry out the responsibilities. The state offices, therefore, had to establish channels of communication to fit both the local and State departments' methods of work through which regulations to protect children could be interpreted and maintained and an agency's qualifications for a license evaluated. Because of continuous changes in personnel locally and in the State departments, the committee came to recognize this task as a continuous process of acquainting various people with the roles of the respective departments in respect to the licensing law.

Material for Guidance

In seeking guidance for working out its problems the committee discovered that there was a dearth of suitable material. It was difficult to find out how other States established standards or what success they had in applying them. As far as the committee could discover the States borrowed ideas from each other that had not been tested through any evaluative research. On the theory that standards should reflect changing concepts and methods of child care, the committee took steps to stimulate studies that would produce some reliable data on applicable standards. A study is now in process to determine reasonable health standards for day nurseries in relation to the ratio of bathroom facilities to the number of children. The committee is sponsoring the study with aid from the University of Washington.

The committee's agenda have always included a topic of mutual concern presented by a guest speaker or a committee member. Some of the subjects have been: newer methods of controlling communicable diseases; types of facilities caring for children outside their own home and their focus of service; principles of fire control and what constitutes a fire hazard; handling, preparing, and serving food; analysis of legislation affecting responsibility of the various departments for licensing and recommendations for carrying these out. The question of having cats, dogs, and birds around children provoked a lively discussion in relation to health protection and educational needs. A description of the health program in day nurseries, prepared by a subcommittee, afforded an opportunity for various types of specialists to work together to assemble material for a report.

A Team Approach

As mentioned previously zoning turned out to be closely related to the committee's responsibilities. At one of the meetings the executive of a city zoning commission, in discussing the principles of zoning codes and their relation to the location of children's agencies, revealed the commission's wish to know more about the types of children's agencies in his city since it was in process of revising its zoning codes. Accepting an invitation from the zoning commissioner to serve as consultant on the needs of children and child-caring agency standards, the committee asked the community council in the city to bring interested parties together to provide information and representation to the zoning commission. Recently a radio report informing the public of the need to revise the zoning codes in this city cited the need for locating day-care centers in residential areas most desirable for meeting the needs of young children.

The agenda for each meeting have also included a review of the licensing status of individual agencies. In the ensuing discussions the committee members have given special attention to those agencies presenting specific problems. Occasionally the committee has felt this type of team approach needed to be carried directly into the agency and consequently representatives of the State Departments have met together with the operator at the agency. Such conferences have clarified the problems both for the operator and the State departments and brought agreement on basic plans for their solution.

These problems have usually centered around an agency's difficulties in complying with one of the State department's regulations. One agency was having difficulty in obtaining equipment to meet the dishwashing requirements. Another could not install a fire-alarm system compatible with its program and the type of children under its care. Several instances have come to the committee's attention of a child-care facility being planned about by an operator whose ability or willingness to meet standards or provide adequate care were questionable. In such instances, each department has agreed to work within a time limit with the potential operator to interpret the responsibilities involved in operating a child-care facility. This procedure has helped such operators to face the problems realistically and has led in each instance either to the termination of the plans or to acceptance of the steps recommended for establishing a good facility. Through a mutual exchange of information the departments have been able to support the recommendations as a whole.

In working closely on such specific problems, the committee has evolved channels for communicating information between State departments. Sometimes these have been committee work, sometimes conferences, sometimes correspondence. There has been less reluctance to share confidential material as confidence in the other specialists' ability has grown. Thus real teamwork has been able to take place. The committee's agreement on methods of approach to each problem and an outline of the procedure to be used by each department has resulted in a clear path for straightforward action. In working together in this manner the departments have found they have sharpened their own techniques.

In Summary

What has the committee achieved? It has established a pattern for working together that can be understood by agency operators. It has shortened the lapse of time between application and licensing by providing for concurrent work by the departments. By initiating pre-application consultation in the departments it has helped potential applicants to crystallize their intentions and be clear about their responsibilities before establishing a child-care facility. It has brought into focus the objectives of standards for children's agencies and their basis in children's needs. It has analyzed and revised standards to fit better with good child-care principles.

Through all these developments interdepartmental relations have been strengthened as have relations between the individual departments and agencies and between the departments and the communities. This can only mean an overall gain in a general understanding of children's needs.

EVALUATING CARE OF THE ORTHOPEDICALLY CRIPPLED

Staff members of the Bureau for Handicapped Children
New York City Department of Health*

EVALUATION of the care currently being rendered to orthopedically handicapped children, still one of the largest diagnostic groups receiving crippled children's services, is important to program planning. It is useful, however, only if based on valid methods and reliable data. In New York City, where the program includes about 7,500 children with orthopedic handicaps, the Bureau for Handicapped Children of the city Department of Health, has for the past 4 years been developing methods for measuring the quality of patient care. Through these methods it has found weaknesses which it has already taken steps to correct.

The data studied came from the following sources: (1) live-birth certificates; (2) surveys of services given in hospitals and convalescent homes to orthopedically handicapped children; (3) the program's register of handicapped children; (4) the State-Aid Medical Rehabilitation (payment) Program; (5) the city's diagnostic clinic; (6) the school placement program for physically handicapped children; (7) other sources, such as national or local accrediting groups. Material from these sources is collated so that what comes from one source supplements what comes from another, thus rounding out the picture.

Case Finding

Birth certificates which include spaces for reporting congenital malformations and birth injuries produce data for measuring the effectiveness of case finding. The information they contain, however, is often incomplete, because the abnormality must necessarily have been found within a short period after birth, usually 48 hours, in order to have been reported on the certificates. While many obvious malformations and injuries can be ascertained that early, others cannot or are not. Possibly more complete material could be obtained from the records of hospital nurseries, or the investigation of certain groups of newborn infants who are potentially more "vulnerable,"[1] such as: those delivered prematurely; those delivered after precipitate or prolonged labor; those of high birth weight; those delivered by high or midforceps, by breech extraction or by Caesarean section; those delivered of women suffering complications of pregnancy; and those who fail to breathe spontaneously at birth.

Data relating to the age of children coming for treatment are also pertinent to the effectiveness of case finding. These are available from diagnostic and consultation-service clinics, from the register, and from the payment program.

In New York City, for instance, we found that of all the children with certain congenital malformations or birth injuries whose care was paid for by the State-Aid Medical Rehabilitation Program in 1953, only 4 percent were infants under 1 year of age, and only 32 percent were in the age group from 1 to 4 years. None of the children with clubfoot were under a year old. Only 5 percent of the children with congenital dislocation of the hip were less than a year old, while 34 percent of them were over 4. Only 17 percent of the children with spina bifida and meningocele were under 1, while 57 percent were over 4 years old.

Such an obvious indication of a delay in case finding or in successful referral to approved medical-treatment agencies suggested a need for greater awareness on the part of physicians and public-health nurses of the importance of early case finding and of the need for more skill in recognizing the signs and symptoms of certain disabilities deriving from prenatal and natal influences.

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Diagnosis, Treatment, and Rehabilitation

Information obtained from a study of hospitals, convalescent homes, and outpatient clinics—either directly through team survey or indirectly through payment for service—can assist in the evaluation of the caliber of care the children are receiving.

In New York City, the diagnosis, treatment, and rehabilitation of orthopedically handicapped children are carried on by hospital outpatient and inpatient services, by convalescent homes, and a diagnostic and consultation service provided by the health department in a large teaching hospital.

To obtain data for evaluation the Bureau surveyed these hospitals and convalescent facilities for information as to: (1) professional qualifications of the directors of their orthopedic, pediatric, physical medicine and rehabilitation, X-ray, laboratory pathology, and anesthesia departments; (2) the degree of responsibility and authority invested in these directors; (3) the policies they had established and the degree of supervision they gave; (4) the qualifications of personnel administering anesthesia; (5) the qualifications of physicians performing orthopedic surgery; (6) whether or not they contained organized departments of orthopedic surgery, pediatrics, and rehabilitation, and, if so, whether these had been approved by the respective medical specialty board for residency training; (7) the frequency of medical rounds and conferences; (8) the provision of other qualified professional personnel, such as nurses, social workers, therapists, psychologists, nutritionists, and the degree of medical guidance and assistance given them by the medical staffs; (9) the capacity and census of the children's orthopedic service, and the length of the waiting list, if any; (10) whether child patients were kept in the hospital longer than necessary and, if so, why; (11) the degree to which the various members of the professional team work together; and (12) how often children were reevaluated by this team.

Because of the importance of maintaining family ties while a child is hospitalized the Bureau also asked about the frequency of visiting hours.

Since only a small percentage of orthopedically handicapped children require hospitalization, outpatient departments provide the device for early case finding, for making an accurate evaluation and diagnosis, for school-placement recommendations, and for providing much of the treatment, supervision, and rehabilitation.

From orthopedic outpatient facilities the Bureau sought information on: (1) whether there is a separate children's orthopedic clinic; (2) whether qualified orthopedists and at least one pediatrician attend the children's orthopedic clinic; (3) the physician-patient ratio; (4) the type of patient history taken, physical examination made, laboratory and X-ray services and counseling given for the evaluation and reevaluation of the patient's condition and progress throughout the course of treatment; (5) the schedule of the patient's revisits to the clinic, and the clinic's follow-up of broken appointments; (6) the degree of supervision given to therapists; (7) the frequency with which children are admitted to the inpatient service for diagnostic procedures not provided for in the clinic; (8) whether or not the clinic completes X-ray and laboratory tests and makes cast changes on the day of clinic visit or requires revisits for the procedures; (9) how often children are reevaluated by the team; (10) the degree of privacy

Two orthopedically handicapped children in a convalescent home choose play equipment from a playcart. More attuned than the hospital to the needs of children recovering from surgery or other treatment, such a home can be a useful stopover on the way back to parental or foster family care.

provided for counseling and guidance to the child and his parents.

In regard to nursing the Bureau looked for: (1) the presence on the staff of a qualified nursing supervisor for both the children's orthopedic and rehabilitation services; (2) the ratio of nurses to both inpatient and outpatient orthopedic and rehabilitation patients; (3) the percentage of nursing staff who are registered professional nurses; (4) the allocation of duties in relation to the personnel's degree of training and experience; (5) the nature of the clinic's program for counseling parents; (6) the degree of home followup and supervision of selected patients by the community public-health nursing agency; (7) the degree of integration of the therapy services and the nursing service; (8) the degree to which the nursing staff participates in team rounds and conferences.

The Bureau also focused on four aspects of social-service departments: (1) the administration, including the professional qualifications and the responsibilities of the director; (2) the quality of professional supervision made available to the casework staff, the size and quality of the staff and the assignments received; (3) the availability of medical social casework services to children and their families; (4) comparison of the size of caseload with the actual number of children under medical care in hospital or clinic. It also considered the timing and nature of referrals to the social-service department; the content of medical social casework services provided to patients and their families; the extent of referrals to appropriate community agencies; the degree of medical social work participation in team planning on behalf of the child and the kind of social data made available for the medical chart.

In its survey the Bureau covered 25 hospitals providing orthopedic services—15 general hospitals, 6 predominantly for orthopedic patients, 2 for chronic disease, and 2 for communicable disease. Since some of these had very few orthopedic patients and none had a waiting list of child patients, some pertinent questions arise: How many hospitals in a highly specialized field can a community afford? Do children receive the better treatment when they are scattered in a number of facilities, or concentrated in a few?

Observations of these hospitals and of their 22 outpatient clinics indicate that while many of them provide some aspects of total patient care, only 2 provide all aspects of care; and many have not yet been able to bring what aspects they do provide together so that the various professional services function as a team for the total benefit of the child.[2, 3, 4, 5, 6] However, the Bureau has found that this step of first hand observations by a team including an orthopedist, pediatrician, physiatrist, hospital nursing consultant, and medical social worker represents the beginning of an educational program effective in improving the quality of care.

A teacher and his pupil. Home teaching for the homebound has become an integral part of the service of many public-school systems. Some, however, are now making efforts to get more homebound children out of their isolation into school with other children, in special or regular classes.

During the course of the surveys, the team members found a number of children in hospitals who did not appear to require further inpatient care. Since overinstitutionalization is not only psychologically hazardous to the child, but also wasteful of community funds, the Bureau set up a committee in 1953, composed of members of the survey team, to review the record of all children who had been in any institution under the aegis of the payment program for a period of 1 year, all children in any institution designated by the team as a "problem institution" and all children with serious or complicated problems of care and rehabilitation.[7]

During the first 6 months of its activities, the committee reviewed, at least once, the situations of 210 children, for whom the payment program had paid for a 120,683 patient-days of care. Of these children, 48 were recommended for discharge to their homes. Forty-seven were actually discharged shortly thereafter. In addition, 37 children with cerebral palsy were recommended for screening for possible admission to special classes in public schools. Of these, 7 were screened and 4 were admitted to special classes, one was placed on the waiting list for admission, and 2 were found to be too mildly handicapped for admission.

Some children in hospitals were recommended for transfer to a convalescent home and vice versa. Some were recommended for foster-family placement; some, for admission to a State institution for the severely mentally retarded, and one, for admission to a residential school for the blind. In general, the better institutions had fewer children who were "overinstitutionalized" than the substandard institutions.

The School-Age Child

Data on services for the school-age, orthopedically handicapped child are obtainable from: the school placement program of the crippled children's agency; the board of education; the records of patients in hospitals and convalescent homes; the diagnostic-clinic service; programs for homebound children or children in special schools or classes; and various organizations, such as parents' groups and parent-teacher groups.

Data from such sources can provide the following information: (1) the percentage of children in hospitals and convalescent homes provided with educational services; (2) the percentages of known orthopedically handicapped children on home instruction or in special schools or classes; (3) medical and health needs of homebound orthopedically handicapped children and of those in special schools or classes; (4) the appropriateness of assignment of children to a home teacher or to a special school or class; (5) the number of children on waiting lists of special schools or classes; (6) the number of children recommended for special schools or classes who are unable to attend because of inadequate transportation service, refusal of admission by school principals, unsuitable school plant, unsuitable housing at home, or other deterrent factors; (7) patient-days of absenteeism from school because of attendance at outpatient clinics; (8) provision of school opportunities for children with more than one physical handicap.

In New York City the evaluation of services to school-age orthopedically handicapped children focused on those who were homebound and those who were in special classes in the public schools.[8] As a result, concerned groups are now considering methods of providing them more adequate services.

After reviewing the cases of the 74 orthopedically handicapped children in Manhattan receiving home instruction,[8] the team members recommended that 29 children remain on home instruction, that 37 return to school, and that 2 be admitted to a hospital for inpatient care. Home instruction was being discontinued for one who was past school age and for 2 who were severely retarded mentally, and plans for 3 were undecided. The team recommended that almost half the children returning to school be admitted to regular classes. Of the 37 recommended for return to school, 18 are now attending school; 15 of these are in regular school classes and are doing well.

The team made specific medical recommendations for 35 of the 74 children and initiated followup procedures. These recommendations included medical care and supervision, other rehabilitation services, the provision of equipment, and weight reduction.

The team also recommended additional social-service assistance for the families of 11 of these children and recreational activities for 17 children. In a parallel study of 49 eighth-grade children [9] in special orthopedic classes, conducted by the Board of Education, an orthopedic surgeon recommended that 15 children be transferred to regular school classes.

Vocational Rehabilitation

Since one of the objectives of a program for handicapped children is the ultimate absorption of the patients into the adult employed community, the vocational aspects of care are part of the evaluation of total care. One criterion is the closeness with which the crippled children's agency works with the Vocational Rehabilitation Service. This closeness can be measured by the degree to which the crippled children's program is involved in: the direct referral of the teen-age handicapped patients to the community vocational agencies; the stimulation of medical-treatment agencies to employ vocational counselors and to refer patients to vocational agencies; efforts to persuade medical-treatment agencies to share vocational counseling personnel.

Data on the vocational rehabilitation of orthopedically handicapped young people may be collected through a variety of procedures: surveys of hospitals' orthopedic services for children; review of the situations of young people who are homebound or who are in special classes; analysis of sources from which young people have been referred to the community's vocational-rehabilitation agencies; analysis of orthopedically handicapped young people reported to the register; and analysis of public-assistance rolls for persons disabled by conditions arising in infancy and childhood.

Of the 74 orthopedically handicapped homebound children evaluated in New York City, 25 were 15 to 19 years of age. At least 11 of these were found to be in need of vocational guidance and were not receiving it.

Prevention

In a sense, data from a program for handicapped children can be an index of the effectiveness of the community's overall health program. For example, an effective tuberculosis-control program should result in the eradication of tuberculosis of bones and joints. An effective maternal and newborn program should result in a significant reduction in the incidence of cerebral palsy and of Erb's and brachial paralysis. An effective accident-prevention program should result in the reduction of disability due to trauma. An effective infant and preschool health program should result in the elimination of rickets as a cause of orthopedic disability. Improvement in the quality of medical and hospital care should result in the elimination of disability due to osteomyelitis. If preventive measures are effective, incidence figures on all these conditions should be decreasing if not disappearing entirely.

In New York City, the Bureau for Handicapped Children attempted to evaluate the preventable factors of birth injuries through an analysis of severe birth injuries reported in 1948. This revealed an association between the type of birth injury and the type of delivery.[10] For example, low and midforceps deliveries were associated with facial paralysis; breech delivery with fractures; Caesarean section with intracranial injury; spontaneous delivery with brachial plexus injury (resulting in paralysis of the arm). An analysis of the type of accoucheur in these cases revealed that 60 percent of the midforceps and 85 percent of the breech deliveries reported occurring on the wards of municipal and voluntary hospitals had been performed by the house staff without a qualified obstetrician in attendance. In the private services of voluntary and proprietary hospitals, 40 percent of midforceps deliveries, 62 percent of breech deliveries, 38 percent of internal podalic versions (turning the baby from a breech to a head presentation) and 25 percent of Caesarean sections were performed without a qualified obstetrician in attendance.

Miscellaneous Aspects

In addition to the type of information gained by the methods so far described other areas must be explored to complete a broad evaluation of services for orthopedically handicapped children. These include foster-family placement, housing, transportation, recreation, and custodial or residential care.

Necessary data for evaluating the foster-family aspects of the program include information on: (1) the number and type of orthopedically handicapped children in hospitals and convalescent homes who are medically ready for discharge and who for social reasons cannot return home; (2) the number and type of such children placed in foster families over a given period of time and the reason for placement; (3) the type of children selected for foster-family placement; (4) the caliber of the foster homes and their accessibility to medical-treatment agencies; (5) the degree of supervision provided to the foster parents; (6) the number of orthopedically handicapped children awaiting placement.

In New York City the Bureau for Handicapped Children has attempted to apply these suggested criteria on foster care in its total evaluation of the care of the orthopedically handicapped. However, so far its data are incomplete.

Criteria for determining housing needs include information as to: (1) the number of orthopedically handicapped children medically ready for discharge from hospitals or convalescent homes who cannot return home because of their families' unsuitable housing; (2) the number of homebound children who are prevented from either attending school, receiving continuous medical supervision and care, or becoming employed, because of the isolated location of their homes; (3) the number of families on waiting lists for low-cost housing who have an orthopedically handicapped child; (4) the provision in low-cost housing of special facilities for the orthopedically handicapped such as ramps, siderails, doors wide enough for wheelchairs, special gadgets, and elevators; (5) the length of time elapsing between application and the actual moving into such housing by families having an orthopedically handicapped child; (6) the degree of priority for low-cost housing given to families having an orthopedically handicapped child.

Criteria for evaluating the adequacy of transportation include information as to: (1) the number and types of orthopedically handicapped children requiring and receiving special transportation to school, to recreational services, and to medical treatment agencies; (2) the size of the waiting list for such transportation; (3) the costs of transportation; the length of time spent by the child during transportation; (4) the type of transportation provided, the use of specially equipped vehicles, and the provision of attendant service.

Data supplying a view of the recreation opportunities for orthopedically handicapped children include information as to: (1) the number of orthopedic services in hospitals and convalescent homes employing trained recreation or group workers and their ratio to the children; (2) the number of regular or special recreational agencies and camps in the community which accept orthopedically handicapped children; (3) the number of orthopedically handicapped children on their waiting lists; (4) the caliber of services they provide; (5) the number of homebound children in need of a recreational program.

Criteria for determining the adequacy of residential care for orthopedically handicapped children include information as to: (1) the number of severely disabled children at home, or in hospitals or convalescent homes, who have no rehabilitation potential and no family or whose family can no longer care for them, who require long-term placement and who are too severely handicapped to be placed in a foster family; (2) the availability of residential services for such children, and the caliber of such services; (3) the number of children needing such care and awaiting placement.

Comment

These techniques for evaluating the care orthopedically handicapped children are receiving might well be applied with appropriate modifications to the care of other handicapped groups including those with rheumatic fever or heart disease, epilepsy, hearing impairment, visual impairment, and mental retardation. For children with any of these handicaps, as for the orthopedically handicapped, an important factor is flexibility of community services so that they can move from one to another as their individual needs change. Such flexibility requires the provision of the services already mentioned, frequent periodic reevaluation of the child, and a good understanding of children's needs by the staff members who serve them.

It also requires willingness on the part of an agency whose function is no longer needed or is being performed better by other agencies to change its interest to needs still unmet. Very likely many communities have adequate funds available to serve the orthopedically handicapped well. Whether such funds are always used to the best advantage for the maximum number of children requiring services will depend on the wisdom, understanding, and leadership displayed by administrators of both the official and voluntary health agencies, and by influential members of boards of the voluntary health agencies

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A judicious writer observes, *Infants should always be cool, but never cold.* But what I esteem of still more essential consequence, and would particularly enforce, is *changing* an infant's clothes frequently. I would choose it should be done every day.

—The Maternal Physician; a treatise on the nurture and management of infants, from the birth until two years old. By An American Matron. 1810.

Earliest book on child care written by an American author.

Experience in an extended institute provides information on . . .

HOW TO HELP HOUSEPARENTS LEARN

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CHILDREN needing placement away from their own homes nowadays present, on the whole, rather serious problems. Group-living in an institution helps many of them with their difficulties, but much depends on the quality of the institution, of its services and of its staff—particularly the houseparents. Because houseparents are actually the hub of the wheel, it is unfair to children for institutions to rely solely upon the intuitive understanding that they may bring to their job, important as it is. They also need special training for the responsibilities they are expected to carry.

Executives of children's institutions for some time have tried to meet this need through inservice training programs and short-term institutes as well as through once-a-week classes extended over a number of weeks.

Such programs have been useful but inadequate. Realizing this a committee of the Welfare Council of Metropolitan Chicago recommended in 1950 that a 5-week full-time institute be provided.

Five years later this plan became a reality. It was made possible by a grant to the Council from the Wieboldt Foundation and by Federal child-welfare services funds allotted for the experiment by the Illinois State Department of Public Welfare. The University of Chicago contributed some of its facilities as well as an instructor from the School of Social Service Administration to serve as the coordinator of the course and as one of the four teachers. The Children's Bureau, U. S. Department of Health, Education, and Welfare, also furnished an instructor. A number of private institutions raised part of the tuition or maintenance for the houseparents they were sending, and in some instances provided housing and meals for out-of-town participants.

The program was designed by the instructors in consultation with the Council's committee to cover the following areas of content: the institutional setting and program; understanding the individual child; understanding the group; the houseparent's role in the health program for the child; feeding children in groups.

As the key courses, those on the institutional setting and program, understanding the individual child, and understanding the group were allotted a total of 15 hours each. The courses on feeding children in groups and the houseparent's role in the health program met for a total of 6 hours each. We decided on two 1½-hour sessions per day for the following reasons: (1) Houseparents are not used to sitting; (2) most of our students had been away for a long time from a systematic learning experience; (3) we intended to stress quality rather than quantity of experience; (4) we wanted to give time and opportunity for outside learning through a free exchange of ideas and experiences among the participants as well as through other media, such as planned visits to local children's institutions.

The committee suggested that in selecting students the agencies keep in mind the productive use the houseparent is likely to make of the training experience and the length of future service he is likely to give. They were asked to consider persons with reasonable emotional maturity, who are receptive to learning, who seem able to change, and who show understanding and warmth toward people, especially children. Applications were not open to persons who carry supervisory responsibility.

Even with such broad criteria, the institutions recommended only 23 students although the committee had planned for 30—perhaps a reflection of, among other things, the generally low caliber of this type of institutional personnel and the justified fear of damaging childern by interrupting relationship with their houseparent.

Being aware of the dulling effects of restricted living, we looked for a pleasant, free setting for the institute and chose International House on the Chicago University campus. Here we had a large, comfortable seminar room which we equipped with a special library of pertinent books, periodicals, and pamphlets. Here too some of the students could stay and take part in the programs sponsored by foreign students or other accessible cultural activities. In order to give the students time to profit by the stimulation of their surroundings written assignments were kept to a minimum.

The 23 participants came from 19 different institutions, 10 of them under private and 9 under public auspices. About half these institutions were for dependent and neglected children and the other half were of various types—for delinquents, the feebleminded, blind, deaf and dumb, and seriously crippled. They also varied as to size as well as in standards.

Among the houseparent-students were 18 women and 5 men, ranging in age from 20 to 60 years. While most of the students had graduated from high school, one had not gone beyond the eighth grade. One had graduated from college and had accumulated several credits toward a master's degree in education.

More than half the group had been houseparents for at least 3 years. Most of them functioned as leaders of small groups consisting of from 8 to 15 children.

Evaluating the Course

One of the institute's courses, Understanding the Individual, was chosen as a basis for a pilot project for evaluating methods. Its selection was dictated partly by the fact that its instructor and the coordinator, who sat in on the course, were the only faculty members present during the entire 5 weeks of the institute; and partly because the anxiety-stimulating nature of its content offered rich opportunities for learning what to give the students, how much to give, in what sequence and in what ways.

Institutions today are increasingly providing training opportunities for houseparents, through both in-service and extra-mural programs. Here the superintendent of a children's home in Florida calls together a houseparents' meeting with a consultant from the State welfare department.

The initial plan for this course was to present in orderly sequence the dynamics of human behavior at various age levels and in various living situations, with particular emphasis on the psycho-social development of a child separated from his parents after having experienced an unhappy and unfavorable home life. The instructor planned to speak in nontechnical language; to stimulate full discussion; and to allow the students to ventilate their feelings.

In the first session, the instructor asked each member to identify himself and his setting, and to describe a situation which he would find easy to handle and one which he would not. Ignoring the former, all the participants presented serious problems and asked for immediate solutions. The instructor then "tabled" these problems, and suggested that the group try to understand them in terms of the body of knowledge of normal growth which she would present. The group assented.

The first three sessions established a relationship within the group and between the group and the instructor and gave the instructor a chance to observe how the individuals reacted to the content.

The instructor began by emphasizing the importance of the family for the child's normal emotional development. She then summarized the crucial stages of normal child development as understood through psychoanalytically oriented theory; explained the dangers of depriving children in regard to their developmental needs; described the healthy and unhealthy ways children have of reacting to their problems; told of the serious effects on children of early separation from the mother; spoke of the emotional problems of children rejected by their parents; openly recognized the difficulties houseparents face in dealing with hostile, angry children; and described their role in providing these children with a good experience with adults.

Shift in Teaching Methods

By the end of the third session, it was clear that these houseparents were alert, energetic, interested, and capable of involvement in learning when the problems *they* brought to the class were used as a jumping-off point for discussion; and that their attention span was more limited when theoretical material was presented through a lecture. They showed little interest in theories of personality development in infancy and the preschool years, undoubtedly because their work was with older children. They showed uneasiness, anxiety, and some hostility when the material was difficult for them to understand and not immediately applicable. They especially showed anxiety in the third session, when the instructor discussed the child's sexual interests. Handling their anxiety by flight, they withdrew their interest and did not participate in the discussion. Obviously they were "problem-solution centered," with a concern for "doing" rather than "understanding the whole child." Seeking answers to *very real* problems, they thought around concrete situations, not theoretically.

Intermingled with their wish for solutions to specific problems, these houseparents also exhibited considerable concern regarding their role with the children and with others in the institution. They expressed feelings that the administration and staff expected too much of them. But they also showed that their expectations of themselves were beyond what was realistically possible.

An appraisal of the houseparents' educational background, the inadequacy of their preparation for their highly demanding jobs, their experiences in living with children, their readiness to learn, and ways of learning led to a reorganization of the teaching content and a modification in methods. At the end of this session the instructor told the group that since the material was too theoretical and unfamiliar the course would in the next period return to a consideration of specific problems, referring to the theories as they applied. The content was also broadened to include discussion of the houseparents' relationship to the individual child, the houseparents' relationship to the team, and the houseparents' relationship to the child's own parents.

Lecturing was sharply reduced. Developmental material was not systematically presented, but was introduced in connection with the problems of children in the developmental stages of those with whom the houseparents worked.

What became clear then was that the houseparents were troubled primarily by overt behavior disturbances expressed in temper tantrums, destructiveness, disobedience, rule breaking, lying, stealing, sexual misbehavior, eating problems, and enuresis. They showed less concern over withdrawn behavior. They tended to focus on a problem rather than on a child and his feelings. Seeing "badness" rather than anxiety and unhappiness decreased their natural feeling of empathy with the child. They maintained that they believed children should be handled according to their individual needs, yet in discussing what to do about lying, they wanted a formula that would be applicable for all children.

When developmental material was handled in an illustrative fashion the group gave full attention and participated. Focusing on their immediate problems helped them to feel free to discuss their own practices and to see the pertinence of developmental knowledge to the problems they faced. What they learned in this way held immediacy for them and thus held greater promise for retention.

Meeting Some Concerns

In meeting the group's concern about rule breaking the instructor agreed that whenever children live together rules are necessary. She then spoke of the positive and negative aspects of rules—their value in giving security to children who have never known any steadiness in their own homes, and the hostility they arouse in those whose early experiences have led them to resent all authority. She drew on developmental material to show the meaning of rules to the normal pre-adolescent child and of the reactions that may occur among children who are anxious, angry or guilt-laden, and pointed out that children are most apt to obey rules when they wish to please those who have won their love and respect. She also encouraged the houseparents to discuss their own feelings about rules and their approach to enforcement.

Some of the houseparents clung to the notion that children learn through punishment. Their punitiveness did not seem to arise so much from a need to punish as from limited knowledge of other means of helping a child to obey. Their ability to talk through a problem with a child was apparently small and they came to the discussions with no concept of a child's learning by identification with them.

The houseparents described the various punishments they used, usually some form of deprivation. The discussion revealed that a number of them disapproved of depriving children of food for any reason. This provided an opportunity for the instructor to explain meaning of food throughout life and the equation of food with love, and how the houseparent who denies food is apt to be cast in the role of the ungiving, withholding mother. When members of the group also told of sending a child to bed as a punishment, the instructor pointed to the inconsistency of using bed as a punishment when it is also the place where a child is expected to get relaxation and sleep. This led to a discussion of fears and of masturbation and of the relationship of the latter to a child's feelings of loneliness or resentment.

In discussing the various methods of punishment the instructor tried to help the houseparents to see that the child's behavior bears a relationship to his whole experience, that the same type of behavior has different meaning for different children and that the relationship of the houseparent needs to be different with different children.

The houseparents were, understandably, greatly concerned about enuresis in children. Some of them thought the children wet their beds out of "laziness" or "spite" or "wanting to remain a baby." However, having observed that most enuretic children did not want to wet their beds and were ashamed of doing so, they decided that the children "couldn't help it."

The instructor tried to get across the idea that enuresis results from an emotional conflict which was not known to the child, and that the houseparents' friendship and protection can be a great help in alleviating, and sometimes even eliminating the symptom. Here again she referred to the part played in the development of hidden anxieties by unfortunate experiences in the child's early relationship to his parents. In discussing what these might be in the enuretic child, the houseparents brought out their own feelings of uneasiness, repugnance, and shame at a pre-adolescent child's failure to control elimination. From this focus the instructor was able to lead them to a consideration of the enuretic child's feelings about himself and the importance of the houseparent's attitudes toward him. When she made it clear that it was not the task of the houseparent to *treat* enuresis, a good deal of tension seemed to be released and a lively discussion about practical aids to decrease the houseparent's physical labor followed. The instructor encouraged the houseparents' use of any reasonable concrete device which the child felt might help him, but stressed the point that whatever help they could offer would be dependent for its effectiveness on the quality of their relationship with the child.

The houseparents' main worry in regard to adolescent children emerged as concern over homosexual practices and problems of heterosexual relations. Homosexual practices especially aroused their anxiety as a violation of their moral code, and they regarded such behavior as symptomatic of serious pathology. Their anxieties in regard to the heterosexual activities of their charges centered largely around the results—out-of-wedlock pregnancies.

In meeting these concerns the instructor presented material on the physical and emotional changes in adolescents and the problems they face of becoming adequate, independent, achieving persons, able to establish good relationships with members of the opposite sex. She referred back to her previous explanation of the child's feeling about the parent of the opposite sex in earlier stages of development and pointed to the possibility of disturbances in this as interfering with heterosexual development. Now

International House, setting of the houseparents' institute sponsored by the Chicago Welfare Council, provided the students with many opportunities to broaden their horizons.

that they could see the relationship of these early experiences to the problems of the older children in their care, the houseparents seemed more able to accept material which they had previously rejected.

While the focus after the third session remained on the houseparents' specific problem, the instructor was able to use the discussions to develop several concepts: (1) that a child's behavior has multiple causes and cannot be explained by one event in his past experiences; (2) that the motivations for much of his behavior are unconscious; (3) that the child's behavior, no matter how disturbing, represents the only means he has been able to develop for meeting his needs; (4) that houseparents cannot and do not need to know all the child's past experiences; (5) that they can and should try to observe the child's behavior and present relationships in terms of their knowledge about him and of normal children and to understand what present needs the behavior serves; and that (6) with this understanding they might help him to meet these needs in a more acceptable way.

The Houseparents

The houseparents expressed a good deal of confusion concerning their role. Some saw it as being a substitute parent and others a therapist. They, nevertheless, seemed dimly aware of having nothing to rely on in their handling of disturbed children but their own intuition. This many found useful, but they expressed realization that it was not adequate for dealing with the highly complex problems that arise in institutional living. Their discussions revealed that even the spontaneous relationships they succeeded in establishing were frequently interfered with by gaps in their knowledge which rendered them indecisive and guilt-laden.

The instructor pointed out that in spite of the "mothering" and "fathering" they necessarily give, houseparents are *not parents* and that this fact held many advantages for them in their relationships to the children—less guilt, less anxiety, fewer expectations and ambitions for them, less demand for a return of their love, and hence greater freedom to see each child as he actually is. She also underscored the fact that they are *not therapists* expected to resolve the child's emotional conflicts. She painted their role as one of helping the child with his everyday problems and relationships and helping him to see new values and objectives.

In the discussions the instructor helped the houseparents to see the importance of understanding the child's behavior and of not giving the child a repetition of the experience he has had with his parents; and to recognize the qualities that this requires—inner strength, patience, an affectionate nature, consistency, fairness, wisdom, and self-awareness. She pointed out the dangers of overprotection, counterattacking when provoked, or bargaining for good behavior.

As these discussions advanced, the instructor and the coordinator became increasingly convinced that the biggest contributions such a training course can make is to help houseparents to be clear about their role and to develop benign attitudes, based on understanding, so that they may use themselves creatively with children. Only when relieved of the burden of having to "cure" the children of their bad habits are they able to grasp the concept that success as a houseparent involves reaching out and establishing the kind of relationship with each child which may help him deal effectively with day-to-day living as well as with his problems.

Most of the houseparents expressed resentment at having no direct contact with the children's parents. In pointing out that almost all the children talk to them about their parents, they revealed a tendency to blame the parents for the damage done to the child. This made it important for the instructor to stress the fact that because parents remain vital forces in the child's life a houseparent can help a child to bear his disappointments in them, not by depreciating them, but by accepting them as they are.

The complaints of the houseparents about demands on them and the inconsistency in the supervision they received led into a consideration of the houseparents' role on the institutional team. In an effort to help them stand up for their right to be counted the instructor supported them in their feelings of needing more recognition as a part of the institutional team and greater help from the team members in achieving understanding of the children in their care. She also recognized their need for improved salaries, working conditions, and participation in planning.

What the Teachers Learned

Experience with this group of houseparents has taught us some principles that seem to have general application for teaching a group of persons who carry closely similar jobs but who have no common background of knowledge, who work in a wide variety of settings, and who have been far removed from formal schooling for years:

1. The instructor in planning course content and method must take fully into account the back-

ground data about the group and be flexible at all times in relation to the interests, aptitudes, and feelings of the students.

2. The students need a "shockproof" teacher who can identify with them, accept their limitations and the limitations in the places where they work; and who can be satisfied with small achievements. In spite of the limitations, the gratifications a teacher may derive out of such an experience are considerable, and are derived not only from the houseparents' enthusiasm and eagerness to learn, but also from the important realization that small changes in houseparents' attitudes will vitally affect the daily lives of many children.

3. The amount of content presented in regard to growth and development and deviations in behavior has also to be related to the length of the institute. How much of this material should be included in a 5-week institute needs yet to be identified. In any case, the teacher must guard against a tendency to try to pass on to the students everything she knows.

4. Teaching normal growth and development has to grow out of the specific problems with which the students are deeply occupied. Out of the multitude of incidents they have experienced involving children, those they tell about in the sessions can be related to current knowledge of what is relatively normal for the child's stage of development and what might be the possible forces underlying disturbing behavior.

5. Presentation of a body of dynamic material via lecture, even though tempered by discussion, does not meet most houseparents' needs. They cannot "take in" until they have ventilated their accumulated frustrations, feelings of inadequacy and anxiety. Therefore the teacher must guard against a strong tendency among social workers to try to teach untrained persons as they do the professionally trained.

As the houseparents are permitted to share their problems with the instructor, they tend to relax and to become franker about their practices and attitudes. Particularly, as the teacher "cuts their jobs down to size," by defining and delimiting their roles and as she suggests the realistic contributions they can make, they begin to show more vigor, new confidence, and hope that they can take better hold of their jobs.

6. A setting for the institute which offers opportunities for mental stimulation outside the classroom may not only present a climate conducive to learning but also may help to broaden the cultural horizons of individuals in the group. We found that as houseparents responded to such opportunities, as most of them did with a little encouragement, they seemed to gain confidence in their adequacy as people.

Appraisal of Results

We have some evidence that this institute has led to some broadening and deepening of knowledge and to some change of attitudes among a number of the houseparents who attended it.

Indications of movement appeared during the latter part of the course. By then resistance in many of the participants seemed to have diminished. Their questions and answers became increasingly more sensitive and thoughtful, and they no longer seemed to be looking for pat remedies with which to cure a child's problem. Many also showed evidence of greater understanding of the individuality of children and of situations and of the need for tailoring their approach accordingly.

Towards the end of the course these houseparents strongly expressed a conviction of their need for more training. When asked for suggestions on how to improve the institute in case it should be repeated, they requested an advanced institute for their own group and another institute for "beginners" to give more houseparents similar opportunities. They followed up these requests with telegrams to the various sponsors of the institute expressing their appreciation of the experience and urging the establishment of more institutes in the near future. Before they dispersed, they decided to start a statewide organization for institutional child-care workers, with the purpose of furthering their training.

Among their suggestions for improving the institute were: (1) live-in arrangements for every participant—to prevent institutions from expecting them to go back to work after the sessions and to make it possible for the group to have social activities together; (2) two 2½ hour sessions with a coffee-break in between; (3) more observation visits to institutions; (4) limiting the content in the course on health to preventive health measures; (5) greater stress on how to work with the delinquent adolescents; (6) cutting the course on feeding children in groups to one or two sessions concerned chiefly with the emotional meaning of food and how to handle feeding problems, since few houseparents carry any of the responsibility for cooking.

No suggestions were made for covering any additional areas of skill or knowledge, such as games, crafts, folk dancing, and children's literature. Perhaps the lack of requests for such practical training derived from a wish not to deflect time from areas in which the houseparents felt insecure to those in which they felt relatively competent.

We also saw evidence that it would take a long time for the houseparents to integrate what they had learned. At a farewell party the group put on a skit in which some houseparents played the roles of the institutional staff members at a staff meeting and others enacted the roles of the children with problems. Here they showed most clearly that they were shaken by the new ideas and experiences to which they had been exposed and that consequently their old patterns of dealing with children had become disorganized, with little reorganization having taken place as yet. At least they were articulate about it.

Before the students left we asked them to write us within a month or two about how they were using their newly acquired knowledge. Twenty of the 23 houseparents responded to this request. Their letters indicated that they were trying to use what they learned as much as possible and had found some of it practical and some of it hard to use. Among the modifications in their approach they mentioned were: they stopped to think before they tried to handle a situation; they no longer felt they had to do something about everything and were more apt to let the children settle their own little disputes; they endeavored to meet troublesome situations with a sense of humor; whenever possible they allowed the children to participate in setting rules and gave them a little more leeway in regard to those already established.

Some of them indicated a lessened need to punish. Thus a houseparent-couple working in an institution for delinquents wrote: "We still have to maintain discipline but we kind of 'sniff' and evaluate a little before we act on behavior problems and many times we find that the kids' behavior is really not so much out of the ordinary."

The letters gave evidence that many of the houseparents were aware of something having happened to themselves during the institute. Here are some excerpts:

"The course taught me to understand and control my own emotions to a much greater extent than I ever thought possible."

"This experience helped me towards a greater acceptance of the children and their limitations whereas before I expected too much of them."

"I can see lots of things I never noticed before."

"I felt many times so inadequate to express what I know, but now my notebooks have become a bulwark of strength."

"The course has made me more confident in my work, and I am not so hesitant any longer about asking help from my supervisor. Before when I had to consult her I felt always inadequate."

Practically all the letters brought out new convictions regarding the importance of good team relationships. Many houseparents also said that they now felt less strain on their jobs and seemed to be able to enjoy their work more than before. Many again expressed hope of participating in an "advanced" institute.

Two months after the institute ended, the Welfare Council sent a letter to the superintendents of the participants' institutions asking for their observations regarding the functioning of these houseparents since their return. Among the many striking similarities in the responses were: the houseparents seemed to have come much more alive and to have greater initative; they showed greater security in dealing with the children; they were more able to individualize each child; they seemed to have become more understanding of and more patient with deviant behavior; they showed signs of having gained a greater self-awareness and a clearer concept of their role on the institutional team; they had learned to communicate better with other members of the staff and, in several instances, relations with fellow workers had improved.

Many superintendents not only mentioned the houseparents' desire for further training opportunities but themselves made a strong plea for more institutes.

This experience and its results confirmed our strong conviction that improvement in the standards of American children's institutions depends a great deal on the contribution social work can make in training houseparents. The establishment of more extended institutes of the type described would seem to be a practical way of beginning to bridge the gap in educational opportunities available to them.

PROJECTS AND PROGRESS

Hearing Defect

The Baltimore Hearing Society recently concluded the first year of a 5-year project to demonstrate that many children with impaired hearing can learn valuable social skills while participating in recreation with children whose hearing is normal.

In April of this year 50 children from 5 to 14 years old with faulty or no hearing were participating in weekend or after-school programs with nonhandicapped children in neighborhood recreation centers throughout the Baltimore area. Some were taking part in two or three programs a week, such as a Scout meeting, a YMCA arts-and-crafts program, and a Sunday School class. During the current summer months a number of residential and day camps are including children with serious hearing handicaps in groups with nonhandicapped children.

Except in unusual circumstances, only one carefully selected child with a serious hearing defect is assigned to a group of children who hear normally.

To select children for the project the Society's recreation therapist pays frequent visits to day schools for children with defective hearing, where he tells the children about the project, learns from the staff which children are likely to profit by it, and chooses those who are interested and who have their parents' consent.

The most important step in the project, according to the Society, is interpretation to camp and agency personnel of the problems created by the child's disability. The Society also views as important the therapist's help in getting the child over the "rough spots" of the experience by attending the first few sessions with him and continuing to drop in on the group from time to time. Frequent reports of the child's progress in the group are sent to his parents, teachers, and speech and hearing therapist.

Some children, the Society finds, are not ready for entering outside groups because they have little understanding of group play and may be disruptive when they attempt it. Consequently, the Society's recreation and speech and hearing therapists hold biweekly play sessions in which a child of this type joins two or three other children with defective hearing who are accustomed to group activities, in the hope that through experience the child may learn to get along with others.

While the Society has as yet made no objective evaluation of the project, reports from parents, teachers, agency personnel, and the Society's staff give evidence of general success. For example, of the 21 children it placed in camps last summer only 2 failed to adjust, and these 2 got along well in a day camp.

These reports also indicate that children with hearing handicaps soon learn to enjoy the group activities but are slower in getting along with the other children, though nonhandicapped children seem inclined to accept a handicapped child on the basis of what he can do.

For this year's camping season the Society has joined forces with the Jewish Community Center, which has been carrying on a similar program for the past 5 years.

Against Polio

For the past several months manufacturers have been producing poliomyelitis vaccine at consistently higher levels, according to the Public Health Service, Department of Health, Education, and Welfare. Monthly production, which reached 8 million cubic centimeters in March and 8.5 million in April, is expected to be even higher by summer.

The question of how to use the supply to achieve optimum results was discussed in mid-April by members of the National Advisory Committee on the Poliomyelitis Vaccine who met with Public Health Service officials of the Department, and in early May by representatives of the health and medical professions at a similar meeting.

These discussions stressed the importance of continuing and expanding vaccination programs throughout the summer months—a view based on evidence accumulated during 1955 that the total preventive effect of the vaccine is much greater than the hazard of provocation.

Early fear that vaccination during the polio season might "seed" an epidemic has been allayed by studies made in epidemic areas during 1955, according to the Public Health Service. For instance, in Massachusetts, which experienced an epidemic last year, no cases occurred in the first 2 months of the epidemic in 157 of the 351 cities and towns where children were given vaccine, and rumors that an undue number of cases had occurred in household contacts of vaccinated children proved unfounded.

To find an answer to the question of whether a vaccination program has any value in checking an epidemic the Public Health Service, upon the recommendation of Advisory Committee, is planning to make extra vaccine available this summer for research in selected epidemic areas. The studies will be designed by State and local officials with the cooperation of the Service's Communicable Disease Center.

In communities where no epidemics occur, the National Advisory Committee recommends that programs be concentrated upon children under 15 and expectant mothers—the groups which in all States have the highest incidence of poliomyelitis. Since most children begin to build immunity within 10 days after vaccination, to continue vaccination programs during any of the so-called "polio months" is expected to reduce attack rates.

In all sections of the country the peak polio season is not reached before July and does not end before October or early November. Therefore, the Public Health Service has decided to continue the vaccine allocation system on a population basis instead of shifting to a regional basis, which would supply larger amounts to the South in the early spring and to the North in the early summer, as had been suggested by some persons.

Under the present system of allocation each State and Territory receives the proportion of each new supply of vaccine which corresponds to the proportion of the population in the priority group residing there. Most of the vaccine is going to private physicians, through commercial sales and through allocations by health departments.

Since in mid-May this year every area still lacked sufficient vaccine to immunize its entire priority group, the Public Health Service has advocated an immediate intensive drive to reach the unvaccinated even though it may only be possible to give single injections to some of them. Studies conducted by various States on the effectiveness of the 1955 vaccination program were based chiefly on single injections and yet show that vaccination reduced the risk of paralytic polio by about 78 percent. Among vaccinated children, most of whom had had only one injection, the attack rate was only 6.3 per 100,000 as compared to 29.2 per 100,000 among the unvaccinated.

Child Development

A longitudinal study of a small group of children is being carried on by Dr. Aase Grude Skard, of the University of Oslo's Psychological Institute, in an effort to find out about personality development of Norwegian children in relation to parental attitudes. For each family the material collected includes wire-recordings of several extensive interviews with parents separately—the first during the prenatal period—and of numerous shorter interviews with the mother; results of standardized developmental tests given the child at specified intervals; and written records of psychologists' observations of mother-child interaction and other facets of family life.

The study was begun in 1950 with the selection of 21 couples at a prenatal clinic, each expecting a baby in a month. All were in fairly low economic circumstances. None had more than one other child.

A psychologist interviewed each of these mothers and fathers to ask about their emotional attitudes toward each other, toward children in general, and toward their coming child, and especially to note their ideas and expectations about permissiveness or the opposite in such matters as feeding and toilet-training. This kind of interview was held again when the child was 6 months old and has been repeated at the end of each year of his life, with the discussion adapted to new problems arising with age and to any changed conditions in the home such as the birth of another baby.

In all but three of the psychologists' monthly visits to the family during the first year, the baby was tested and the mother interviewed. The other three visits were devoted to observation of mother and child at the baby's bathing and feeding times. After the first year the intervals between visits were lengthened.

Dr. Skard plans to coordinate the results of the study with those found by workers in other countries.

Juvenile Delinquency

Under recently enacted legislation in New York State every county in the State will establish a youth court to provide special treatment for defendants 16 through 20 years of age. The new law provides that every alleged offender between the ages of 16 and 21 must initially be brought before a youth court, which must have an investigation made by a probation officer before assignment of the case to its own or a criminal court. Noncriminal proceedings, until now permitted only for boys and girls under 19 years old, may be held at the discretion of the youth court for any defendant under 21. Under noncriminal proceedings the defendant is not charged with a crime, but with being a "youthful offender," and if guilty he is not given a criminal record, though the arrest remains on record.

The 1956 New York Legislature also voted an additional $80,000 to help local authorities carry on youth projects designed to reduce juvenile delinquency. It also created a permanent Youth Commission to assist such projects, replacing a temporary one appointed some years ago.

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Data from 977 juvenile courts that reported to the Bureau in both 1954 and 1955 show a 9-percent increase in juvenile delinquency cases in the latter year. Preliminary estimates based on information from a group of 383 courts that have been reporting to the Bureau for a longer time also show a 9-percent increase during the 1954–55 period. On the basis of these data the Bureau estimates that about half a million children were brought before the courts for delinquency in 1955.

While the 9 percent increase was occurring, the population of 10–17 year olds (generally the group within the jurisdiction of the juvenile court), went up only about 3 percent, according to the Bureau of the Census. The latest Federal Bureau of Investigation Uniform Crime Report, based on data from 1,162 cities, shows an 11.4-percent increase in police arrests of young persons under 18 in 1955 as compared with 1954.

Cerebral Palsy

Preliminary planning has been nearly completed for a collaborative project on cerebral palsy, coordinated by the National Institute of Neurological Diseases and Blindness, Department of Health, Education, and Welfare. As part of an effort to discover genetic and environmental factors in the origin of this condition, neurologists, neuropathologists, obstetricians, and pediatricians will make clinical and pathological investigations in numerous hospitals. Babies showing signs of stress at birth, or neurological symptoms afterward, will be selected for study, with normal babies as controls.

Information to be collected on each case, according to an outline developed by a group of 15 scientists representing various fields of medical research, include family data, especially the mother's antepartum, intrapartum, and postpartum history; a record of events at the baby's birth; his clinical history and a record of clinical examinations; and a complete record of pathological findings. In case the baby dies, autopsy records will be collated with the other findings.

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Study of the prenatal and natal history of each child with cerebral palsy, as a step toward learning how to prevent the condition, was urged at a round-table discussion held recently at the New York Academy of Medicine under sponsorship of the Coordinating Council for Cerebral Palsy in New York City.

At least one cerebral-palsy clinic in New York is already sending clinical information on patients to the hospitals where they were born, so that each child's condition can be studied in relation to his obstetric history, it was reported. Without such information, a panelist pointed out, an obstetrician often does not know that he has brought a cerebral-palsied baby into the world, for the condition is seldom recognizable at birth.

All the panelists agreed that a close relationship exists between prematurity and cerebral palsy. Better living standards and better medical care in helping to prevent premature birth would help to prevent cerebral palsy also, it was suggested. Since more than half of the babies born in multiple births are premature, special attention in their prenatal care was recommended.

Improved methods of judging the condition of the placenta before birth will help greatly in preventing cerebral palsy, according to one panelist, who noted that such improvements might take place in the next several years. A report of the conference is available from the Council, 47 West 57th Street, New York 19, N. Y.

Unmarried Mothers

For the third successive year North Carolina's Board of Public Welfare has increased its help to counties for the care of unmarried mothers and their babies. Because of other demands in the State's program on the funds it has available for child welfare, the State has so far extended this aid for only part of the year through the use of Federal child-welfare funds. In the first year of the program, 1954, the program could be operated only 2 months. In 1955 it was lengthened to 3 months. In 1956 it will last for 5 months. The Board hopes that eventually the program can be offered throughout the year.

The plan enables county departments of welfare that do not have funds for this purpose to pay for the cost of maternity-home care up to a maximum of $200 for each woman admitted. For the 5 months of this year's program the Board made available $15,000—$11,000 to be used primarily in rural counties, and $4,000 in areas of special need. The Board's Division of Child Welfare pays the maternity-home fee at the time the woman is admitted. The State allows the money to be used for care in approved homes outside the State as well as within it and makes no resident requirements.

The county welfare department assumes all casework responsibilities concerning the care of the unmarried mother and her baby, including placement of the baby for adoption if that is decided on.

Mental Health

A mental-health study in New York City schools is being planned as part of the 3-year school-health survey now being carried out by the Welfare and Health Council of New York City in cooperation with the city's board of education and department of health, and supported in part by a grant of $160,000 from the Public Health Service of the Department of Health, Education, and Welfare.

Like the health survey as a whole, the mental-health study will, through teacher observations and other techniques, screen sample groups of elementary and junior-high school pupils for disturbances.

The aim of the entire survey is to determine the effect of the city school health service in placing children with health problems under appropriate care and in improving methods of referral so as to facilitate proper and timely treatment. Both public- and parochial-school children are included.

Mental Retardation

A 3-year study of technical planning in the field of mental retardation has been begun by the American Association on Mental Deficiency with a grant of $232 million from the National Institute of Mental Health, Department of Health, Education, and Welfare. Designed by the Association's committee on research, training of personnel, and program development, the project is to be carried on by subcommittees in these respective areas.

One subcommittee will suggest subjects for needed research, to appropriate institutions or agencies and help them carry out the research. Another will study the personnel in the field of mental retardation—in relation to number, background, previous training, professional standing, economic status, and university affiliation—and will design recruitment plans. A third subcommittee will review and evaluate current and past programs, point out unmet needs, suggest new steps, and encourage demonstrations.

With headquarters at the State school for the mentally retarded at Columbus, Ohio, the project's staff will compile reprints and disseminate information on various aspects of mental retardation and work with the mentally retarded. Abstracts and reviews of pertinent material will be published in the *American Journal of Mental Deficiency.*

. . .

New York State's Legislature recently provided for establishing additional special classes for mentally retarded children, especially in rural areas. School-census information in cities other than the largest ones in the State henceforth must include data on children with mental defects. Two pilot diagnostic and parent-counseling centers are to be set up by the State for children in whom mental retardation is suspected—one in New York City, the other in the central part of the State. The work of these centers will be evaluated by a professional research team.

UNICEF

The United Nations Children's Fund recently allocated $8,398,800 to assist child health and welfare projects in 47 countries and territories in 1956. More than a third of this sum—$3,246,000—will go for anti-malaria campaigns carried on jointly by UNICEF and the World Health Organization. Basic maternal and child welfare services will account for $1,558,800; long-range feeding projects, $1,282,600; and programs for conservation of milk and other foods, $605,000. Other programs aided include efforts to control tuberculosis, yaws, trachoma, leprosy, and typhus. Beside these long-range programs, the allocations provide for emergency aid in India ($55,000 for drugs) and in Korea ($800,000 for direct feeding programs for children and nursing mothers).

Here and There

More children will have a chance to drink milk under the Department of Agriculture's Special School Milk Program in the next 2 years than in the first 2 of its operation. Legislation enacted by the 84th Congress in April 1956 broadens eligibility for the program to children in nonprofit nursery schools, child-care centers, settlement houses, summer camps, and similar institutions chiefly serving economically underprivileged children. It also raises the ceiling on Federal funds to be used annually for the program from $60 million to $75 million. The new conditions went into effect July 1, 1956.

. . .

Six to nine national awards for "fundamental and imaginative" contributions to the well-being of children, in the fields of education, physical and mental development, social welfare, and communications will be made annually, beginning this year, by a newly formed nonprofit organization, Marshall Field Awards, Inc., which has headquarters in New York City. Purpose of the plan, according to the organization, is to "focus public attention on children's needs and on the areas in which improved services are urgently required."

. . .

This fall many orthopedically handicapped children, previously homebound, will be able to attend school in New York City through the use of newly designed buses, provided by the city's Board of Education. Easier to board and leave, the new buses have their first step nearer the ground and the other steps lower than those of the old buses. Special buses for cerebral-palsied children are also planned for the next school year. These will have lifting equipment, space for wheelchairs, and trained attendants to help children get in and out.

Facts and Figures

The rate of childbearing by American women 15 to 44 years of age rose about 11½ percent between 1950 and 1954, according to the U. S. Bureau of the Census. The rise was mainly among women 20 to 30 years of age. Among girls 15 to 19 the rate did not rise.

. . .

One and a half million marriages took place in the United States in 1955, according to an estimate by the National Office of Vital Statistics, Department of Health, Education, and Welfare. This represents a 3-percent increase over 1954. Divorces were 1.6 percent fewer in 1955 than the 379,000 divorces in 1954. In 1953, the last year for which data on children in divorced families are available, an estimated 330,000 children under 18 were in families broken by divorce. During that year there were 390,000 divorces; in about a fourth of them two or more children were involved.

. . .

Old-age and survivors insurance benefits were paid in mid-1955 to more than half of all paternal orphans under age 18, and to almost two-fifths of the widows with children. In the event of the death of the family breadwinner, some 50 million of the Nation's 56 million children are now assured of monthly OASI benefits until they reach 18. Old-age and survivors insurance also affords some protection to 90 percent of the married women in the country with children under 18 against loss of support because of the husband's death.

Guides and Reports

GOALS AND METHODS IN PUBLIC ASSISTANCE. Family Service Association of America, 192 Lexington Avenue, New York, N. Y. 1956. 64 pp. $1.

A collection of articles selected from 1955–56 issues of *Social Casework*, discussing the social-work concepts on which the public-assistance programs are based and the application of casework principles in administering them.

THE CHAPEL HILL WORKSHOPS, 1955. Child Welfare League of America and University of North Carolina School of Social Work. Chapel Hill. 1955. Processed. 50 cents.

The proceedings of two 5-day workshops to discuss institutional care of children in 17 States—one for houseparents, the other for administrative personnel. Subjects include: a code of ethics for houseparents; responsibilities and privileges of parents; the hostile adolescent; punishment.

PROCEEDINGS, ANNUAL MEETING, NATIONAL COMMITTEE ON HOMEMAKER SERVICE, Chicago, Ill., October 20–21, 1955. Children's Aid Society, 150 East 45th Street, New York 17, N. Y. 85 pp. Processed. $1.

Includes papers on many aspects of homemaker service: responsibilities of public and voluntary agencies providing it; broadening its use; ways of interpreting it to board, staff, and community; supervision and training of homemakers; organization and financial support; and relationships between agencies providing homemaker service and other groups.

FILMS ON THE HANDICAPPED; an annotated directory. Jerome Rothstein and Thomas O'Connor. International Council for Exceptional Children (a department of the National Education Association), 1201 16th Street NW., Washington 6, D. C. 1955. 56 pp. $1. Annual supplements, 20 cents each.

Films listed in this directory are grouped by type of disability, such as emotional maladjustments, mental retardation, and visual handicaps.

AN INVENTORY OF SOCIAL AND ECONOMIC RESEARCH IN HEALTH. Compiled by Frederick R. Stone. Fourth edition. Health Information Foundation, 420 Lexington Avenue, New York, N. Y. 1955. 266 pp. Available on request to the Foundation.

Contains descriptions of nearly 400 current and recently completed research projects dealing largely with the social and economic aspects of health programs and health problems.

A SYLLABUS ON A CURRICULUM FOR THE RETARDED CHILD. Written by the staff of PARC Training School. Sponsored by Philadelphia County Chapter, Pennsylvania Association for Retarded Children, Philadelphia, Pa. PARC Training School, 555 E. Adams Avenue, Philadelphia 20. 1955. 35 pp. 50 cents.

Describes three programs—nursery-school, regular-class, and home-training.

SCHOOL NURSING SERVICES. National League for Nursing, 2 Park Avenue, New York 16, N. Y. April 1956. 60 pp. $1.

A report of a 5-day conference in which representatives of the fields of nursing, medicine, public health, school administration, and health education discussed how the services of the qualified nurse can be used most effectively in furthering the health of school children.

THE EXCEPTIONAL CHILD FACES ADULTHOOD; proceedings of the 1955 Spring Conference of the Child Research Clinic of the Woods Schools, held in New York City May 6 and 7. Woods Schools, Langhorne, Pa., 1955. 114 pp. Single copy $1. Reduced prices on quantities.

Reports the fourth in a series of conferences dealing with the problems of mentally retarded children at various stages of life.

BOOK NOTES

TRUANTS FROM LIFE; the rehabilitation of emotionally disturbed children. Bruno Bettelheim. The Free Press, Glencoe, Ill. 1955. 511 pp. $5.

Second in a series of three volumes explaining the work of the University of Chicago's residential school for children with severe emotional disturbances, this book is devoted mainly to detailed descriptions of the treatment and reeducation of three boys and a girl. The author, who is superintendent of the school, explains that he did not choose the four children merely to show their improvement, as better success stories were available. These four were the only ones who, at the time the report was begun, had received at least 3 years of treatment by his methods and had been followed up for another 3 years.

The appendix presents tabular information on 40 children (the school's average enrollment) and their families.

WHAT WE LEARN FROM CHILDREN. Marie I. Rasey and J. W. Menge. Harper & Bros., New York. 1956. 164 pp. $3.

In this book the authors, both educational psychologists, describe their experiences in helping children with mental or emotional difficulties to learn to become responsible, self-directed persons and in learning for themselves from these experiences. Illustrating their report with numerous incidents in which children's actions have stimulated their thinking, they tell how they revised or sharpened their ideas on the type of environment children need, methods of nurturing child growth, and the role of purpose in human behavior.

"Such principles as we found," they report, "still required special application to different situations and with different people."

OUR BLIND CHILDREN; growing and learning with them. Berthold Lowenfeld. Foreword by Herbert R. Stolz. Charles C Thomas, Springfield, Ill. 1956. 205 pp. $5.50.

Written by the superintendent of the California School for the Blind, this book presents facts about blindness and detailed advice on helping a blind child to develop independence. In discussing the effects of parent attitudes on the blind child's development, opportunities for schooling, and special methods of teaching, the author answers a number of questions parents of the blind often ask.

An appendix lists books and articles on child care in general and on the blind, sources of information on educational facilities for blind children, and addresses of organizations devoted to service for the blind.

MOTHER-DAUGHTER RELATIONSHIPS AND SOCIAL BEHAVIOR; a study of some aspects of mother-daughter relationships and the social participations of a selected group of schizophrenic patients treated in St. Elizabeths Hospital in Washington, D. C. Rose Cooper Thomas. Social Work Series No. 21, Catholic University of America Press, Washington, D. C. 1955. 369 pp. $4.

Basing its design on the hypothesis that disturbances in parent-child and especially mother-daughter relationship are significantly related to schizophrenia, this study compares the history of 18 pairs of sisters—1 psychotic and 1 not—and finds significant differences between patients and nonpatients in their relationships to their mothers and in social participation.

HEALTH OBSERVATION OF SCHOOL CHILDREN; a guide for helping teachers and others to observe and understand the school child in health and illness. George M. Wheatley and Grace T. Hallock. Second edition. McGraw-Hill Book Co., New York. 1956. 488 pp. $6.50.

This revised edition of a book first published in 1951 gives increased emphasis to accidents in childhood and youth and to the need for intensifying safety education in the schools. It brings up to date the material concerning infectious diseases, including the immunization timetable, and presents a completely rewritten section on poliomyelitis to include development of the Salk vaccine. New sections call attention to reports on the effectiveness of fluoridation of communal water supplies in reducing the occurrence of dental caries and discuss compatible and incompatible blood groups and the Rh factor.

EXCEPTIONAL CHILDREN. Florence Goodenough, with the assistance of Lois M. Rynkiewicz. Appleton-Century-Crofts, Inc., New York 1956. 428 pp. $4.50.

Planned to give those who deal with exceptional children a better idea of such children's needs, this book offers specific advice about working with the intellectually superior child, the intellectually inadequate, the child with an unusual combination of mental traits, and the physically handicapped. The author is professor emeritus of child psychology at the University of Minnesota's Institute of Child Welfare. Stressing the importance of normal human relationships to every child, she asserts that such relationships will be damaged if the child feels too different from other children. Attributing much of this feeling of difference to misdirected sympathy for the defective child and over-praise for the superior one, she maintains that helping children overcome their feeling of being different is the most important duty of persons who deal with exceptional children.

SPEECH HANDICAPPED SCHOOL CHILDREN. Wendell Johnson, Spencer J. Brown, James J. Curtis, Clarence W. Edney, and Jacqueline Keaster. Harper & Bros., New York. Revised edition. 1956. 542 pp. $4.50.

This revision of an earlier work, designed to prepare the remedial speech instructor and the classroom teacher to work together in the interests of children with speech difficulties, deals with three major questions: (1) What kinds of speech disorders are found among school children? (2) What can the classroom teacher do about them, on her own or in cooperation with a speech correctionist? (3) What are the basic examination methods and remedial approaches of the speech correctionist in dealing with these problems? The new material includes a section on articulation of speech sounds and a list of agencies that serve students of speech and hearing problems and children and adults who have such problems. The five authors include four specialists in speech and speech pathology and an audiologist.

MECHANISMS OF CONGENITAL MALFORMATION; proceedings of the Second Scientific Conference of the Association for the Aid of Crippled Children, June 15–16, 1954. Association for the Aid of Crippled Children, 345 East 46th Street, New York 17, N. Y. 1955. 137 pp. $3.

Efforts to find out what causes a fetus to develop abnormally are discussed in this summary of the proceedings of a conference held in New York and attended by 43 scientists, representing not only obstetrics and pediatrics, but a number of other fields, such as embryology, epidemiology, mental health, neuropathology, orthopedics, physiology, psychology, and zoology.

One paper describes a study showing detrimental effects on animal embryos of low oxygen and high temperatures and points out relationships between stages of gestation of human fetuses at the time when environmental stress occurs and types of malformations.

The other papers give reports on studies of the fetus' adrenals and blood, of interaction of materials between mother and fetus, of association between congenital malformations and the family's socio-economic status, and of the basis of the newborn infant's respiratory control.

THE FIELDS OF GROUP PSYCHOTHERAPY. Edited by S. R. Slavson. International Universities Press, New York. 1956. 338 pp. $6.

This is a collection of 19 papers showing how group psychotherapy is used in various fields including, among others, services for families, unmarried mothers, and delinquents; child guidance; treatment of allergies; and community mental health.

ON CALL FOR YOUTH; how to understand and help young people. Rudolph M. Wittenberg. Association Press, New York. 241 pp. $3.50.

Written for group leaders and ministers, teachers and parents, this book stresses interaction between young people 14 to 17 and adults. The author advises his readers on such problems as "how we can be more helpful, when to be firm and when to be lenient, whether to step in or stay out, how often to repeat advice, and how to say no effectively." He points out some differences between typical and sick behavior, so that these adults might be able to spot young persons who need specialized help or therapy.

YOUR ANNUAL MEETING; how to make the most of it. Bernard Carp, Ph. D. National Publicity Council for Health and Welfare Services, 257 Fourth Avenue, New York 10, N. Y. 1955. 168 pp. $3.50. $2.50 to members of the National Publicity Council.

Addressed to health, welfare, and civic organizations, this "how-to" book offers help in preparing for the annual meeting, holding it, and evaluating it. An appendix presents a checklist of things to remember before, during, and after the meeting.

International Publications

YOUTH'S OUTLOOK ON THE FUTURE; a cross-national study. James M. Gillespie and Gordon W. Allport. Doubleday & Co., New York. 1955. 61 pp. 85 cents.

Examines the attitudes of more than 1,800 college students—men and women—in 10 different countries toward their individual and collective futures. The experiment in international social research reported here was carried out with the collaboration of social scientists in New Zealand, South Africa, Egypt, Mexico, France, Italy, Germany, Japan, Israel, and the United States.

TRAINING FOR SOCIAL WORK; second international survey. United Nations Bureau of Social Affairs. E/CB.5/305 Rev. 1,1 ST/SOA/25. New York. 1955. 160 pp. Sales No. 1955. IV. 9. $1.25 from International Documents Service, Columbia University Press, 2960 Broadway, New York 27, N. Y.

Like the report of the United Nations' first international survey of social-work training, published in 1950, this publication focuses primarily on training for students planning to enter professional social work. It also discusses preparation for auxiliary and community workers and inservice training for employed workers. Included are data from more than 50 countries.

INTERNATIONAL CHILDREN'S CENTRE, 1950–1955. Published by the Centre, Château de Longchamp, Paris. 1955. 60 pp. Copies may be had without charge, in French or English, from the Public Relations Service of the Centre.

This report describes 5 years of effort to fulfill the purposes of the Centre: "Intended to encourage the study throughout the world of problems relating to childhood, the dissemination of a knowledge of hygiene and puericulture, and the technical training of specialized personnel." The Centre is supported jointly by the French Government and the United Nations International Children's Fund.

POLIOMEYELITIS VACCINATION; a preliminary review. Technical Report Series No. 101. World Health Organization, Palais des Nations, Geneva, Switzerland. February 1956. 40 pp. For sale by International Documents Service, Columbia University Press, 2960 Broadway, New York 27, N. Y. 30 cents.

Reporting on a meeting of scientists representing nine countries, convened at Geneva November 1955, this publication reviews various countries' experiences with polio vaccine, discusses testing for safety and for effectiveness, and notes criteria agreed on for selection of strains of virus for inactivated vaccine. It also discusses theoretical complications of vaccination, live-virus vaccines, and design and techniques of serological surveys, and answers some questions facing a health officer who has to decide whether or not to recommend polio vaccinations as a general health measure. The report also summarizes the views of the group on the routine use of polio vaccine and outlines problems for further research.

FILMS ON CHILD LIFE

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

THE VALIANT HEART. 30 minutes, sound, black and white, purchase or rent.

Tells the story of an 8-year-old boy's successful fight against rheumatic fever and shows how a community can attack the problem.

Audience: General public.

Produced by: MPO Productions.

Distributed by: American Heart Association Film Library, 13 East 37th Street, New York 16, N. Y.

THE WISCONSIN CLEFT PALATE STORY. 36 minutes, sound, color, purchase or rent.

Shows services necessary for habilitating a child with cleft palate.

Produced by: Bureau for Handicapped Children, Wisconsin State Department of Public Instruction, in cooperation with the University of Wisconsin Medical School, the State Department of Speech, and the University Hospitals.

Distributed by: University of Wisconsin Photographic Laboratory, 1204 West Johnson Street, Madison, Wis.

CAN WE IMMUNIZE AGAINST PREJUDICE? 7 minutes, sound, black and white, purchase or rent.

Points to three different ways of trying to bring up children free of racial and religious prejudice.

Audience: Any adult group with capable discussion leader.

Produced by: Center for Mass Communication with the cooperation of the Anti-Defamation League of B'nai B'rith.

Distributed by: Center for Mass Communication, Columbia University Press, 1125 Amsterdam Avenue, New York 25.

FACING REALITY. 12 minutes, sound, black and white, purchase.

Gives examples of psychological defense mechanisms. Shows an adolescent boy covering his feelings of frustration and failure by negative, face-saving, and attention-getting behavior. Suggests that counseling will help him.

Audience: Parents, general public, and older adolescents.

Produced by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

Correlated with the book, "Psychology in Living," by Herbert Sorenson and Marguerite Malm.

Distributed by: Same.

MIKE MAKES HIS MARK. 29 minutes, sound, black and white or color, purchase or loan.

Shows how teachers and a school counselor, with some help from the community, helped a boy decide that staying in school would offer him greater rewards than leaving to go to work.

Audience: Parents, teachers, teacher-training classes, community groups.

Produced by: Agrafilms, Inc., for the National Association of Secretaries of State Teachers Association.

Distributed by: (sale) National Education Association, Division of Press and Radio Relations, 1201 16th Street NW., Washington 6, D. C.; (loan) State education associations.

THE SEARCH (A Series)

Produced by: Columbia Broadcasting Co.

Distributed by: Young America Films, Inc., 18 East 41st Street, New York 17, N. Y.

"Juvenile Delinquency." Wayne University. 25 min., sound, black and white, purchase.

Illustrates four basic types of delinquent behavior in boys and discusses some of the contributing factors. Tells about a joint effort by a university and a city police department to control delinquency.

Audience: Police and probation workers, teacher-training classes, parent-teacher groups, parents and foster parents, clergymen.

"Child Development." Yale University. 25 min., sound, black and white, purchase.

Discusses new ideas and techniques used in finding out whether a child's mentality is normal. Shows a psychologist interviewing a young couple about to be parents, developmental tests being given to children of various ages, and the final stage of a "natural childbirth."

Audience: Parents of young children and expectant parents.

"Diagnosis and Treatment of Deafness in Children." Johns Hopkins University. 25 min., sound, black and white, purchase.

Explains the procedures carried out at a hearing and speech center to determine what percentage of hearing remains in a young child whose hearing is impaired, stressing the importance of beginning a training program early.

Audience: Parent-teachers and other adult groups, students preparing to teach young children.

DESIGN FOR GROWING. 33 minutes, sound, color, purchase.

Shows how the Cleveland public schools work to develop creative possibilities in children by integrating the arts with other features of the curriculum.

Audience: Parents, teachers, student-teachers.

Produced by: U. S. Information Agency for overseas use.

Distributed by: United World Films, Government Films Department, 1445 Park Avenue, New York 29, N. Y.; 605 West Washington Street, Chicago 6, Ill.; 7356 Melrose Avenue, Hollywood 46, Calif.

WHAT ABOUT DRINKING? 11 minutes, sound, black and white, purchase.

Shows a group of teen-age boys and girls discussing the pros and cons of the use of alcoholic drinks. They reach no conclusions, but leave the question open.

Audience: Parents; teen-agers.

Produced by: Young America Films in cooperation with Yale Center of Alcohol Studies.

Distributed by: Young America Films, Inc., 18 East 41st Street, New York 17, N. Y.

READERS' EXCHANGE

KONOPKA: *Yes, but how?*

Mrs. Konopka's thoughtful analysis of the knowledge and understanding which a housemother should have in order to help the children in her care, raises the question, "Yes, we know, but *where* shall she get this knowledge and *when?*" ("What Houseparents Should Know," by Gisela Konopka, CHILDREN, March–April, 1956.)

Some steps have been taken. Here and there schools of social work and colleges are offering courses; institutes and workshops are held in connection with various conferences. Institutions are also giving more attention to in-service training but much more could be done in this direction. It is helpful when the housemother learns by means of on-the-spot happenings and as she discusses children familiar to all the staff at staff meetings and psychiatric consultations.

Some child care staff members participate in psychiatric consultation sessions within the institution, but this is a comparatively small group of the total number of houseparents. And while the efforts on the part of schools offering short courses are commendable, as are the institutes and the workshops, still all of these things do not really prepare houseparents for all they need to know. Nor do they supply the skills necessary to help the seriously hurt and upset children in their care. Just as a teacher or a nurse needs preparation before she begins to teach or to take care of sick patients, so should the housemother have training before she takes over a group.

In this connection, it was a special privilege and joy for me to see a carefully developed course being offered to students at the Zürich School of Social Work, in Switzerland, under the skillful leadership of Anni Hofer. This 2-year course, including classroom and field work, was developed more than 10 years ago. Its graduates, who have been placed in institutions year after year, have done much to raise the standard of the care of the child in his living group. Other courses for houseparents are offered in England, Holland, and some of the other European countries. From these, we in America have much to learn. And, of course, with training, should go recognition and prestige, together with a whole revision of the salary scale of housemothers, and adequate time off for periods of rest and recovery from this strenuous and draining work.

Eva Burmeister
Institutional Consultant, Social Planning Council of St. Louis and St. Louis County

TARJAN: *An unrealized blueprint*

I have read with interest Dr. Tarjan's comprehensive blueprint, "What Hospitals for the Mentally Retarded Can Achieve" (CHILDREN, May–June 1956). This description unfortunately applies to lamentably few institutions in our country, and even in those many of its aspects still remain in only a blueprint stage. However, progress is being made.

Residential institutions for the mentally retarded provide care and training for approximately 10 percent of the mentally retarded population in this country. However, their importance goes much beyond their services. They represent, at the present time at least, a vital facility for the training of professional personnel of many kinds, for the development of techniques of management—medical, educational, and otherwise—as well as for the demonstration of the advantages of specialized competent care in relation to prognosis. Moreover, they represent concentrations of clinical material without which pertinent research in many related fields would be seriously handicapped.

Therefore, the institutions will eventually determine, in great part, the effectiveness of our present attempts to enlarge community services and facilities for the benefits of the remaining 90 percent of the mentally retarded who are, and probably should remain in their homes. Thus, effective institutional programs are, and will continue for many years to be, a pivotal consideration in the over-all problem of the mentally retarded. It is in this framework of relationships that Dr. George Tarjan's article should properly be considered.

Dr. Tarjan has mentioned the striking changes that are taking place in the nature of the inmate population. Not many years ago, at least 50 percent of the admissions represented the minimally retarded. Much of the educational and training programs were confined to this group. The increasing rate of successful community placements is evidence that they have profited from this. However, the proportion of admissions of the minimally retarded is rapidly declining as our community programs enlarge and improve. The moderately retarded—those with intellectual capacities that at maturity will range between 25 and 50 I. Q.—are gradually becoming the dominant admission group.

Programs designed for the former will not suffice for the latter. Concepts that discounted completely the possibilties of eventual community placement for the moderately retarded must be reexamined. These new problems will require new philosophies and new techniques of management and community supervision. Blueprints designed for today will soon be obsolete.

Only one principle will remain, and this Dr. Tarjan stressed: to develop a kind of program that will result in the "maximum of achievement and independence that the mental capacity will allow."

Herman Yannet, M. D.
Medical Director, Southbury Training School, Southbury, Conn.

Some real goals

Dr. Tarjan is thoroughly up to date in stating the problem confronting residential facilities for the retarded; in emphasizing the need for a multidisciplinary approach to this problem; in projecting institutionally acquired techniques and procedures to the community or non-institutional situation. He has set some real goals.

His reference to functional grouping is especially well taken, for these is a vital need for social training to shore up the community adjustment. So too is his reference to research and to personnel training in all categories, though he has touched upon these subjects rather lightly.

Some objection might be raised to designating the residential facility, as a "hospital" when, except in isolated instances, the preferential term has been "school" rather than "institution." The terminology is confusing enough to parents as it is.

The trend toward utilizing residential schools for care of the severely retarded has been increasingly apparent for some time. More recently concern over the retarded with concommitant physical, emotional, and sensory handicaps has come to the fore. This demands a complete break from the traditional pattern of institutional operation and a new comprehension of the complex nature of retardation.

Edward L. Johnstone
The Woods School, Langhorne, Pa.

SCHERER: *Valid concepts*

When I was first faced with protective casework service I began by questioning, as has Lewis Penner, (Readers' Exchange, CHIDREN, May–June 1956, page 119) why so much stress on such service as different from family casework. Now in teaching protective casework to staff I frequently find the same reaction. And yet our practical experience in Missouri has borne out the validity of the concepts presented by Miss Scherer in her article. "Protecttive Casework Service," by Lorena Scherer, CHILDREN, January–February 1956). Only as workers have accepted specific limitations of time, of focus, of philosophy, have they been able to be of maximum help to neglectful parents.

Mr. Penner objects to beginning with specifics in working with the parent. He asks, "What about the mother who loves her children but who is immobilized by anxiety? Or the father who recognizes his wife's mental illness but is confused about taking appropriate action?"

What we find is that such parents are usually overwhelmed by their many problems and burdens. Too often a worker tends to be overwhelmed too. By beginning with a specific complaint, both worker and parent have a tangible problem with which to come to grips and begin a process which may, and usually does, end in an amelioration if not a solution of some of these other interlocking problems.

Again, there is the matter of focus on the parent as against treatment of both parent and child as the object in protective casework service. It is most important in protective casework that the worker focus on the parent and not the child, lest she lose her greatest asset in this service—giving to the parent faith in his ability to change to meet his child's needs.

Mr. Penner takes issue with "the focus of treatment is on the parent part of the person" suggesting that treatment " . . . in one case may mean relieving an inadequate parent of part of his burden and in another treatment of a neurosis." Generic casework to parents includes many kinds of treatment. But one of the distinguishing features of protective casework as outlined by Miss Scherer is its challenge to the parent to change *in order to give his child proper care.* This is the motivation for inner change, for requesting and using resources, for taking responsibility for his situation.

It is the very singleness of purpose of protective casework, the specific framework of its application, that makes for its effectiveness.

Betty Adams
District Child Welfare Supervisor, Missouri Division of Welfare, Southwest Missouri

A needed approach

Lorena Scherer's article was a real contribution to the literature on protective services. She spelled out clearly the approach that needs to be used in administering a protective casework service program . . . From my reading and experience with caseworkers, I have found a good deal of uncertainty and vagueness in respect to the approach to a neglect situation needing protective casework service.

Fred H. Steininger
Director, Lake County Department of Public Welfare, Gary, Ind.

STITT AND BURKE: *Direct service, too*

Definitely, as Dr. Pauline Stitt and Bertha Burke have pointed out, ("Nutrition Services for Crippled Children," CHILDREN, March–April 1956), one cannot neglect the nutritionist's services in providing comprehensive care for crippled children.

The possibilities of primary prevention of crippling conditions in humans by good nutrition, have been relatively unexplored, with the few exceptions mentioned by the authors. Recent investigative work by Dr. L. V. Ponseti and coworkers at the State University of Iowa, pertaining to the metabolism of mesodermal tissues, indicates significantly that many orthopedic conditions in children—such as primary scoliosis, Legg-Perthes' disease, slipped capital femoral epiphysis—may be related to dietary abnormalities. In view of this and other data, it becomes imperative to have good nutrition established not only for expectant mothers, but before pregnancy, to insure optimal nutritional environment for the offspring from the time of conception.

I consider it important to advocate a more active role for the nutritionist in crippled children's services than that of a consultant. Certainly, the consultant role, as defined by the authors, is important. However, the interest, training, and ability of the nutritionist warrants her direct service to crippled children recurrently, in a manner similar to the functioning of physical therapists, speech therapists and others on the professional team.

The important benefits to be derived from this direct service include (1) improvement of the crippled child's nutritional status itself, (2) favorably changing adverse food patterns of the crippled child's entire family, and (3) affording improved chances of healthy offspring in later pregnancies of the patient, mother or female siblings. Subsequent to this proposed direct service, the public-health nurses and medical-social personnel must assume the role in follow-up, just as they do in regard to recommendations made by the physical therapist, speech therapist, and others.

Raymond R. Rembolt, M. D.
Professor of Pediatrics and Director, University Hospital School for Severely Handicapped Children, State University of Iowa

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DIAGNOSES OF CHILDREN SERVED IN THE CRIPPLED CHILDREN'S PROGRAM, 1953. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 29. 1956. 25 pp. Single copies available from the Children's Bureau without charge.

This bulletin reports that in 1953 from 50 to 100 per 100,000 children in the population of the United States as a whole received service in Federally aided programs for each of the three largest diagnostic groups of crippling conditions—congenital malformations, diseases of the bones and organs of movement, and poliomyelitis.

The rates for diagnostic groups are given for the United States and for each State participating in the CC program.

YOUR CHILDREN'S BUREAU; its current program. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. No. 357. 1956. 61 pp. 20 cents.

This booklet shows how the Children's Bureau works to advance the well-being of children and their families, through its own activities and through working with others in and out of Government. It includes the text of the act of Congress establishing the Bureau in 1912 and of other legislation affecting its work; and a selected list of its publications.

INTERVIEWS FOR STAFF SELECTION IN PUBLIC WELFARE; report of the National Workshop on Interviewing for Staff Selection, held at the New York School of Social Work, August 23–September 3, 1954. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau and Bureau of Public Assistance. CB Pub. No. 355. 1956. 24 pp. 15 cents.

The workshop reported in this bulletin was planned to help staff of State public welfare agencies to improve their methods of selecting social workers through better interviewing of applicants. As part of the training, each participant interviewed a number of applicants who had volunteered to take part in the procedure. The report presents the group's discussions of the principles of interviewing. Staff members from public welfare agencies in 16 States took part in the workshop, as well as representatives of the Children's Bureau and the Bureau of Public Assistance.

JUVENILE COURT STATISTICS, 1954. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 31. 1956. 20 pp. Single copies available from the Children's Bureau without charge.

The year 1954 was the sixth year of increase in delinquency cases reported to the Children's Bureau by juvenile courts, according to this report. In 1954 the Bureau received reports from 937 courts which included in their jurisdiction about 43 percent of the children 10–17 years of age in the United States.

THE COMMITTEE FOR THE WHITE HOUSE CONFERENCE ON EDUCATION; a report to the President. The Committee. April 1956. 126 pp. 40 cents.

The first section of this three-part report offers the Committee's statements and recommendations, based on its own studies of the needs of elementary and secondary schools and on the discussions of these needs held at 53 State and Territorial conferences and at the White House Conference that met at Washington November 28–December 1, 1955. The second and third parts summarize the conclusions reached by the participants in the White House Conference and the findings of the State and Territorial conferences.

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Changing Patterns of Family Life

The U.N. and Human Welfare

Search for Mental Health

Casework as a Partnership

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VOLUME 3
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The happy Liberian mother and her baby are among the hundreds of thousands whom the United Nations Children's Fund, working with the Liberian Government, has protected from malaria and yaws. UNICEF has helped to provide the insecticides, laboratory equipment, drugs, and transport needed by the Liberian authorities in their attack on these two widespread diseases. This is but one of many programs around the world in which the U. N. or one of its Specialized Agencies is helping a government boost opportunities for health and welfare. Others are described on page 170.

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Harold L. Wilensky derived part of the theories he presents here from an analysis he made with C. N. Lebeaux of the impact of industrialization on social-welfare services in the United States, soon to be published as "Social Welfare and Industrialization," by the Russell Sage Foundation. A graduate of Antioch College, with a doctorate from the University of Chicago, Dr. Wilensky worked in labor unions, a social-research organization, and an adult-education project before becoming a professor. Now on leave from Michigan he is spending the current year at the Center for Advanced Study in the Behavioral Sciences at Palo Alto, Calif.

Dr. George S. Stevenson has been with the National Association for Mental Health since its formation by the consolidation of three national organizations in 1952. Previously he was medical director of one of the three merging organizations, the National Committee for Mental Hygiene. In addition to working for the association, he serves as psychiatric consultant to the Public Health Service, a member of the medical advisory service of the American Red Cross, psychiatric consultant to the Veterans' Administration, and a member of the Advisory Committee on Problems of Alcohol to the National Research Council.

After 7 years in public welfare and graduate training, at the University of Chicago, Alice Overton worked for several years with children first in foster care and then in correction. Through this experience, she reports, she developed the wish to work with families, in the hope of preventing the separations which occur through neglect, delinquency, or family conflict. In the New York City Youth Board and later in St. Paul's Family-Centered Project she found opportunities for adventure in adapting casework methods to this end.

In addition to carrying on his responsibilities as superintendent of a home for dependent children, Frank M. Howard lectures in child psychology at the New York State Teachers College in Albany and at the Albany Medical College. Before taking his present position 7 years ago, he was for 6 years executive director of the Children's Service League in Springfield, Ill., and for 6 years a caseworker with the Children's Aid Association in Boston, Mass. A clinical psychologist, trained at Rutgers University, he also worked for a number of years in child-guidance clinics.

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A sociologist speculates on the impact of the new urbanization and industrialization on . . .

CHANGING PATTERNS OF FAMILY LIFE

HAROLD L. WILENSKY, Ph. D.
Assistant Professor, Department of Sociology, University of Michigan

TWO VIEWS are popular today as to what is happening to the American family. A proponent of one, family expert Carle C. Zimmerman, says the family is dissolving. Divorce is on the increase; more wives are working and therefore spend less time with the family; the marriage contract is becoming less sacred and more secular; parents are losing authority over children. Above all, an "unbridled individualism" and a decline in the spirit of self-sacrifice have led to a decline in the birth rate; women are less willing to bear large broods of children. The decay of the family heralds the decay of civilization itself.[1]

The second view, expressed in the statements of another family expert, Joseph K. Folsom, holds that the family is simply changing its organization, and will emerge strengthened, better adapted to a democratic society. The double standard in sex is declining; choice of mate is more voluntary; mechanization of the smaller home plus a flood of goods and services have reduced the drudgery of housework; males are less dominant, women have more equality in law and in daily living; the liberalization of divorce laws and a decline of church authority make it easier to get rid of a cruel husband. Above all, a partial shift of traditional family functions—protective, educational, economic—to the State, school, and industry makes family members more independent of one another and strengthens the family as an adaptable emotional unit. Love, freed from economic compulsion and parental authority, may become more loyal and permanent. Companionship and satisfying affection in the family will create men who are less inclined to sabotage democracy in the community.[2]

Both experts are correct in their facts; their interpretations stem from different value premises.

My task in this paper is to link these facts to some major changes in our society—changes which America experiences in common with other countries undergoing industrialization and urbanization. I will assume throughout that the smaller drama in which we are all intimately involved, the daily drama of family living, is a reflection of the larger and less intimate drama of unfolding industrialism. I will assume further that predictions of what family life will be like 10 or 20 years from now must rest on predictions of what an advanced industrial society will demand from its members in the way of obligations and offer in the way of opportunities.

Industrialism and the Family

A student of industrialization suggests that "modern industry and the 'traditional' family are mutually subversive."[3] Commercial agriculture and the factory system everywhere, if they are to develop, must force the breakup of the economically self-sufficient extended family. What this means can be understood by contrasting the kinship systems of

Adapted from a Lindeman Memorial Lecture given at the 1956 Forum of the National Conference of Social Work, prepared with suggestions from G. E. Swanson, R. Freedman, and D. G. French.

nonindustrial society with the family system prevailing today in the American urban middle class.

While many variations exist in the American kinship system among ethnic groups, social strata, and regions, the urban middle-class family pattern—the one most closely fitting the needs of modern industry—is fast becoming a model for the population as a whole. Sociologists have identified in this a number of main features:

(1) "Family" for midcentury America generally means the nuclear or conjugal family of parents and nonadult children living at home. Other kinsmen are all "relatives," regarded as far less important.

(2) The marriage bond is the key. One's first kinship loyalty is unequivocally to spouse and children. Interests and place of residence tend to be independent of both pairs of parents. The nuclear family acts together on matters economic, social, and political. It is a close-knit unit.

(3) Choice of mate is relatively free. In contrast to nonindustrial societies, casual dating and competitive courtship are the rule and personal choice of mate is emphasized. The choice of mate is not a major threat either to parents or to relatives for, generally, they will not have to live with nor support the newly married couple. Because economic pressures and kinship pressures to stay married are weaker, love is expected to hold the couple together; and if it does not, the parties may be regarded as "maladjusted" or "immature."

(4) Small families are still the fashion despite the current baby boom. In 1790 the average number of persons per family in the United States was 5.2, excluding relatives, lodgers, servants, and others. In 1950 it was down to 3.2. Most of the drop had taken place in the previous 50 years. During the recent boom, the number of families with five children has not increased and the number with six or more has continued to fall. Studies in the Detroit area suggest an overwhelming consensus among all strata of the urban population that 2, 3, or 4 children are "ideal"—and the achievement continues to be lower than the ideal.[4]

(5) The accent on the nuclear family may increase emotional intensity among its members. There is little evidence here, but the argument seems plausible: If family size is smaller, if "relatives" become more distant, if the husband's and wife's contacts outside the family are "functionally specific" (more businesslike), and the child's relationships in school and play group are more competitive, then the family becomes the main source of psychological security and the emotional ties among its members are intensified.

Mobility and Emancipation

Modern industry demands a large, mobile, and motivated labor supply. Here we find a clue to the great emphasis on the nuclear family in the American kinship system.

In March of each of the last 5 years, almost 1 in 5 of all people in the labor force lived in houses other than those they had lived in 12 months earlier; about 1 in 20 lived in a different county. If conditions for this time of high-level employment are typical, then the average worker in an era of prosperity may be expected to change his residence about 8 times in his working life; 2 or 3 of these moves would involve a change of community.

Most of this migration is in response to changing economic opportunity. Job changes also go with changes in family size. About the time the young couple needs more room because of children, they need more money too and they hunt for both better housing and better jobs. Most of such shifts occur in the first 10 years of marriage.

The connection between such mobility and the accent on the nuclear family is easy to see. If one picks up and moves every few years, one cannot bring along 10 or 20 in-laws, brothers, sisters, uncles, aunts, and cousins—especially if they too are moving about at a great rate. Moreover, if one is oriented towards "success" and success is to be had by investing one's money and energy where they will be readily available for transfer to more profitable commitments, then one thinks twice before undertaking lasting obligations—financial, emotional, or otherwise—to extended kin of varied social status. A man who moves up in the world from a traditional Chinese family buys his *father* a house that fits his new position: the whole clan comes along. A man who moves up in the world from a poor American home would surely buy *himself* the house, though he might visit his father once a year or even help him get into a home for the aged.

Such mobility and the emancipation that it brings can, of course, be disruptive. The emancipation of youth, of women, of the aged, as we all know, has involved painful adjustments. We can find illustrations in two of our current social problems—the stranded aged and families broken by divorce.

The Stranded Aged

In nonindustrial society, increased age typically brings increased power, prestige, and security. The oldest members of the clan are treated with the most respect and have the most authority. Parenthood is a kind of old-age insurance.

In the nuclear family of industrial society all this is changed. Here, children have the duty to build their own careers and set up their own households and a corresponding right to independence. They leave the family one by one until the older couple is finally left alone.

At this point, all of the things that happen to old people become very much more tragic. If one spouse dies, the widow or widower is not generally expected to move in with a married child. If he does, it occasions much strain on both sides. Another feature of industrialism, accelerating technological change, means a continual rescrambling of jobs; existing skills are diluted or made obsolete. This hits the older skilled worker hardest. If he is displaced or retired, he has no clear claim to support from his children. Should he be subject to disabling illness or debilitation, his children's emancipation from him becomes an even more difficult load to bear. In this system, parenthood in retrospect becomes for many not old-age insurance, but a thankless task.

Millions of Americans are not many years off the land—rural people used to a comfortable extended-kinship system. In fact, about 1 in 3 of our nonfarm residents grew up on farms. The generations are thus bound to clash; and the dismay of the old, who hold to the old ways, and the guilty consciences of the young who are moving to the new, are painful evidence of the conflict.

While the industrial emphasis on the nuclear family leaves aged parents stranded, their numbers multiply. Everywhere the advance of industrialism increases the chance of dying from old age instead of epidemic disease or malnutrition. Thus, in the United States the population has doubled since 1900, but the number of persons 45 to 64 years has tripled, and the number 65 and over has quadrupled.

Broken Families

A family can be broken in many ways—divorce, desertion, annulment, legal or informal separation, premature death. Except for death, all these causes of family disruption have probably been on the increase. However, we have no official statistics on desertion and separation. The evidence is better on divorce; and the studies unanimously show an almost uninterrupted increase in the divorce rate over the last 90 years. The peak was reached in 1946—one divorce to every four marriages made that year. This reflects both the breakup of hasty wartime marriages and the wartime backlog of delayed divorces. Since then there has been a slight decline; but it is my guess that the long-term trend will not be sharply downward.

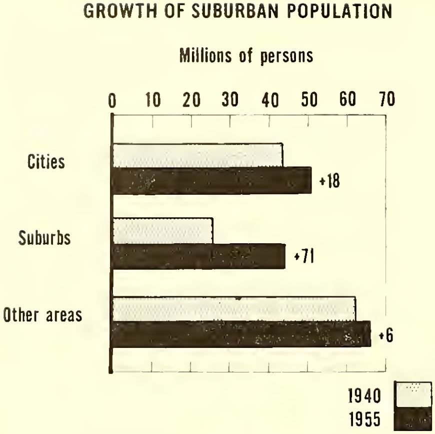
The trends in divorce are similar in all Western nations permitting divorce. They accord with the kinship picture in industrial society previously described. With extended kin sliced away, with deep lifelong friendships outside the family thwarted by great mobility, a heavy emotional load is put upon the small nuclear family. Feelings of guilt about aid to aging parents add to the load.

Industrialism provides another source of strain on the family. Everywhere the rise of industry is accompanied by agitation for the emancipation of women both within the family and within society. With the varied and complex jobs it provides, an industrial society tends to challenge traditional criteria of work assignment like sex and race, and to accent ability to perform. Advancing industrialization puts more women in the labor force—about a third of all those at work or seeking work in the United States are women. It also gives the edge to *married* women—at midcentury the number of married women at work exceeded for the first time the number of single women at work.

Women work to supplement family income (an aspect of rising levels of aspiration for self and children), to support their families (a necessity, for an increasing number head broken families) to achieve "self-fulfillment" (a reflection of the changing definition of woman's role), and because the opportunities to work have increased.

However, the view still prevails that women's work should not put them in competition with their husbands, that their careers, if they have careers, should be subordinate to their husbands', that the demands of a job are in conflict with the demands of the home and of "scientific" childrearing.

One of the strains imposed on the newly emancipated nuclear family, then, is a conflict between a rising insistence on equality with men in competitive occupational achievement, on the one hand, and continued blocks to equal competition and new demands for expertness in home and family management, on



As the chart shows, suburban populations increased out of all proportion to the general growth in population from 1940 to 1955—rising by 71 percent while the numbers of people living in cities rose 18 percent and those living in other areas only 6 percent. During the period the population for the entire country increased by 12 percent.

the other. Women have become disaffected from traditional marital and family roles without getting released from housewifery; they have achieved new privileges, more equal with men's, but are uncertain of what contribution they ought to make to the new partnership.[5]

The load on the nuclear family increases, relations with aging parents get difficult, and the wife's role becomes ambiguous. At the same time, economic and kinship pressures to stay married grow weaker. The increased divorce rate and the shift in popular attitude on divorce from severe disapproval to mild disapproval are reflections of these basic changes in the kinship system.

Divorce is not new. It is not peculiar to our time or our society. Among both modern nations and primitive tribes are those in which divorce rates are probably higher than ours, for example, modern Egypt or the Hopi Indians of North America. But in these societies divorce is not a social problem; in ours it is. The explanation lies in the different consequences for the children where the kinship system rests on the immediate family and where it rests on wider kin groups, which can act as shock absorbers.

Among the Hopi, a married couple lives with the wife's parents and her sisters and their husbands. The core of the clan is a closely knit group of females. Married men look upon the households of their mothers or sisters as their real homes.

Hopi divorce has little significance either to the participants or to their society. If his wife does not bother to thank him for the grain he brings home one day—a sign she is "fed up" with him—a man simply packs up his personal effects and tools and moves back to his mother's or his sister's home. Generally the economic adjustments are minor—enough men are left among the wife's unmarried brothers or brothers-in-law to continue the farming. Little emotional shock attends the break because husband-wife intimacy is only slightly greater than the intimacy among all the adults in the household. The children, bound to their mother's kin, also remain much as before, with many substitute "parents" available. The high Hopi divorce rate is no social problem.

In contrast, marital discord and divorce in our own society have heavy consequences. Too often the child becomes the adult's tool for achieving consolation or revenge. Parents compete for his custody, though not for his support. The principles by which the court disposes of him are vague. The societal machinery for dealing with him seldom operates smoothly; too much attention goes to pinning the blame on someone.

Emerging Stability

In its initial stages, industrialization everywhere uproots people from traditional ways of life and places a strain upon the family.

But open the package of industrialism wide and the picture changes. Many students believe that continuing industrialization and the newer suburbanization that goes with it will in time bring greater stability to family life and may even lower the divorce rate.

For perhaps the first time in the history of the world a large portion of the people who must work in big cities now have a choice: they can live in a dense urban settlement; or they can move to the less crowded metropolitan ring or fringe—a satellite city, a suburb, or even a rural area—and commute. They seem to be choosing the fringe over the center. In the last two decades the population of metropolitan rings has grown almost three times as fast as central cities. Within the ring, the unincorporated rural territory has grown faster than the rest. The central city has practically exploded and scattered itself over the countryside.

Suburbs are by no means uniform either in physical appearance or way of life. They include small residential communities as well as thin ribbons of houses and farms along major highways. Part of suburban growth has been orderly and planned and has resulted in garden cities with adequate education and health and welfare facilities. Part has resulted in "suburban sprawl"—shanty towns, mud-rut streets in partially developed subdivisions, homes mixed up with factories and stores. As Bogue suggests, no one yet knows whether the proportion of the suburban population living under "good" conditions is larger or smaller than the proportion in our central cities—whether we define "good" in terms of services and physical living conditions such as adequate housing, schools, libraries, churches, streets and water and sewage systems, or in terms of low indices of "disorganization" as evidenced in crime, delinquency, and mental disease.[6]

Suburbanism as "a way of life," may have different meanings. On the one hand we have a picture of the "outgoing life" in "mass-produced suburbs" like Park Forest, Ill., or Levittown, Pa. Journalists William H. Whyte, Jr.,[7] and Harry Henderson [8] have described young middle-class, college-educated suburbanites on the make, transients who expect quickly to move on and up, but who meanwhile engage in almost frantic participation in neighborhood and community affairs. They participate partly because their ages, incomes, and occupations are so alike that social activity becomes the basis of prestige and partly because the children get organized and then organize their parents. On the other hand, there are industrial cities like Flint, Mich., whose factory-dotted suburban area contains proportionately *more* manual workers than the city. In this area, one in four homeowners built his house for himself—a time-consuming enterprise which may be one reason why *fewer* Flint suburbanites join formal organizations, including churches, than city residents. Here life is not so outgoing.[9]

Variations, yes. Nevertheless, the evidence suggests the possibility that the suburbs are setting a pattern for a newer family form that will embrace both Flint and Levittown. The suburban family tends to be somewhat larger than the central-city family. It attaches a more positive value to children and becomes more important in the daily routine of its members. Suburban parents not only try to take their child-rearing cues from medicine and psychology; many of them also try to supervise the education and recreation as well as courtship of their children more closely than is possible in the central city. On the other hand, the fringe family seems to be more approving of mothers going to work, especially when their children reach adolescence.[10] The suburb may be the place where women are finding new identity and resolving their conflicts.

These tendencies can contribute to family solidarity. The blue-collar and white-collar workers who "live out and work in" may thus get the chance to increase their family stability at the same time that they increase their job mobility. The suburban home becomes the more-or-less permanent base, the central city *and* its ring become an economic hunting ground—with job moves tied less closely to house moves.

New Patterns

Suburbanization aside, there are reasons to believe that mature industrialization will in itself bring new patterns of family life, and perhaps reverse the longtime trend toward family instability. The new technology of automation and atomic power will accent two general tendencies in our social structure:

1. The growth of the new middle class, a mass of salaried white-collar and professional people. An ever-smaller proportion of the labor force will be needed for direct production, a greater proportion for service, especially jobs requiring brainwork and customer or client contact or both.

2. A merging of the upper blue-collar worker with the new middle class. He has already merged in income and possessions. For the first time in this century more Americans own their own homes than rent; the middle-class package—a car, an electric stove and refrigerator, an automatic washing machine, a deep freeze—is becoming widely distributed; leisure has come to all. With increasing automation, the merger may become more complete. Blue-collar work is becoming more mental and less physical, more a matter of alertness and sense of responsibility and less a matter of manual dexterity.

True, the whole pattern of living is sustained by a heavy bet on the future—long-term mortgages for the home, the installment plan for the package. As for leisure, in millions of homes it takes two jobs and often many overtime hours to put the family in the middle-income bracket. Under these circumstances the achievement in income equality is precarious, for even a mild recession can quickly reverse the trend.

Increasingly, however, the typical urban industrial man, white-collar or blue-collar, suburbanite or not, makes his living in big organizations, doing a job requiring more skill or education or both than his father had. He gets paid more for fewer hours. The large bureaucratic organization, which tends to be more stable and have longer lines of promotion than a generation ago offers him a regularized career. His striving is more ordered, less accompanied by risk and worry. A vast variety of government and private welfare programs greatly increase his security. These developments on the work front are important to the family for there is evidence that the way a man gets his living affects the way he rears his children and spends his leisure time.

A careful study of Detroit mothers by Miller and Swanson [11] illustrates how differences in work environment can be reflected in child-rearing philosophies and practices. They found sharp contrasts between the child training of families whose heads work in large bureaucratic organizations and those whose heads were more free enterprising or less used to urban living. Parents who were non-risk-taking wageworkers or salaried employees in big hierarchical organizations, put less accent in their child training on an active, independent approach to the world; they were also less concerned with "internalization" and with development of strong "built-in" self-control, but encouraged an accommodating adjustive way of life.

The world of work increasingly demands the human-relations skills needed to find one's way around the big organization; the family reflects this in its child training.

With striking consistency the recent studies of urban life underscore the nuclear family as the basic area of involvement for all types of urban populations. Far from a madly mobile rootless mass, disintegrating for want of intimate ties, we find an almost bucolic contentment with the narrow circle of kin and close friends and with spending leisure-time with the family at home—caring for children, watching TV, working in the garden, reading. Occasionally the typical middle-class urbanite makes forays into the world outside—mainly to visit relatives, sometimes to demonstrate a lightly held attachment to a formal organization or two. When he moves, it is part of the life plan.

As industrialization pushes us toward the 4-day week, as work becomes more ordered and secure and income more regular, home and leisure are going to be even more than they are now the central interest of a man's life.

Of course, this somewhat idealized picture applies more to the growing new middle class than to the rest of the population. But this model of family life is diffusing through American culture. Two great new "melting pots" will speed the diffusion: 1) the middle-class suburb where the up-mobile, blue-collar worker learns to behave more like his white-collar colleague; 2) the large bureaucratic organization—factory, office, hospital, or store—where all come to value and practice the regularized life.

Implications for Service

All these changes have long-run implications for social services and for social workers. They point to:

1. New clientele. With the decline of poverty and the emergence of a massive middle class, the trend toward more diversified clientele on a fee-for-service basis will speed up.

2. Broader goals for family counseling. A broader clientele and greater acceptance of social work as a professional service will give family counselors a chance to move their goal beyond emergency adjustment. They will have a better opportunity to strive for optimal development of the client and to be more receptive to the idea of organizing clients to plan this for themselves.[12]

As work fades into the background and leisure is pursued for its own sake, new possibilities for family strain and conflict develop. Think of a woman who increasingly feels she should be part of her blue-collar husband's leisure activities. Then think of her husband who once could get away from it all by retreating into an all-male world (the tavern, the ball game, the fishing trip). Today, even if his wife does not pressure him for joint participation in new and different leisure routines, he finds these last strongholds of maleness contaminated by women's presence. Even the factory is decreasingly an all-male sanctuary.

As the family becomes more occupied with consuming than producing it may need help here, too, from running into trouble. William Whyte [13] describes 83 young suburban couples in the $5,000–$7,500 bracket whose management of money would have shocked their counterparts of a generation ago. Obsessed with a desire for regularity in money transactions, they prefer the high-interest installment plan to the free charge account; they show colossal indifference to and ignorance of 12- and 18-percent interest rates on loans at the bank or "revolving credit plans" at the department store. Family counseling? They need some simple induction into middle-class home management.

Family-serving agencies of the not-so-distant future can make a major contribution to family life by thinking through such problems as the creative use of leisure and the rational use of money. We will all be having plenty of both.

3. Problems of boomtowns and ghost towns. One possible outcome of the spread of automation when coupled with cheap atomic power is the more frequent occurrence of the boomtown-ghost town cycle, resulting from a more mobile industry. A plant or a whole industry now tied to a location close to relatively fixed sources of power soon may be able to locate anywhere it can get labor and raw materials. Factories in the cornfield are already part of the swing toward suburbanization of population and industry. As demands for products change, as these factories become obsolete, some of them will move and leave their labor stranded.

When industrial towns are brand new and booming, social workers can do much to dramatize and meet the need for adequate welfare services; when these places become ghost towns, social workers can provide testimony on the need for broadened income-maintenance programs, for job information, and for moving allowances to smooth the shift of families out of depressed areas into a new life elsewhere.

4. Planning for the new suburbia. Many of the changes affecting families must be met by community organization and planning efforts. In shaping the new suburbia, we need to think a bit more in utopian terms.

The British have been debating about the "life-cycle community" for some time and Whyte tells us about American real-estate men who see its commercial possibilities. You enter such a community, let us say, at the age of 26 with wife and baby, and rent a two-bedroom court apartment. Three years later, when the income is up and baby number three is on the way, you buy a low-priced, three-bedroom ranchhouse not far away. This suits for about 5 years, and you and your upmoving friends one by one launch into more expensive split-level jobs. Fifteen years later when the children have married and moved away, you sell the house and go back to the two-bedroom court where you started. The young couples just beginning the journey are delighted to have you around as babysitter.

Other less cosmic plans emerge from day-to-day decisions we all make about our homes and families. I am referring to the kind of decision my own family and our neighbors are facing. We live in one of these sapling suburbs loaded with young children. Shall we put up hedges between our properties or shall we leave clear space on the crosscutting downslope in our backyards which the kids use for sledding in the winter? Not a big question, but answers to it and hundreds of other small problems will doubtless have major cumulative impact on the quality of family life in our neighborhood.

To help people become aware of their values and alternatives in small decisions like this and in major decisions like housing choice and to help them seek mature development on their own are tasks that offer large opportunity for family-serving agencies of the newer, richer, more challenging age of atomic power and automation.

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How the UN and its Specialized Agencies cooperate in . . .

INTERNATIONAL EFFORTS FOR HUMAN WELFARE

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ONE DAY 7 years ago, when I was serving as an Assistant Director General of the World Health Organization at Geneva, a cable came from New Delhi, India. It reported an outbreak of typhus in the nearby country of Afghanistan. The Government of Afghanistan had asked our WHO office in New Delhi for help. Would the Geneva headquarters, the cable asked, approve the sending of a little team to head up a fight against this dread disease? Our answer was yes.

Within a few days, two Indian health workers, armed with dust guns, kits, and DDT, arrived at customs on the Afghan border. The customs officials were dubious at first about letting these foreigners and their paraphernalia through. At length they gave in.

The WHO health workers, setting up shop in Kabul, the capital, pitched in. They mobilized a team of Afghan assistants. Each was instructed in how to dust the clothing and bodies of men, women, and children. The resistance of customs officials to this humanitarian invasion was as nothing to the initial resistance of citizens to being dusted. A few—tortured by the ceaseless itching of the typhus-carrying lice—took a chance. The first night, after being powdered with DDT, these brave ones discovered they could sleep. They spread the good news to others. More and more people came to be treated. In a remarkably short time, the typhus epidemic was brought under control in this one small section of the country.

Today, 7 years after this event, hardly a single adult in Afghanistan is untouched by the changes that have been taking place in a country which geography had left isolated from the march of knowledge for 1,000 years. Some of the changes have come about from the technical aid which the United States has been contributing. Many are traceable to the many-faceted technical assistance programs of the United Nations which are helping the Afghan Government lift its people out of ill health, illiteracy,

These young seamstresses learned to sew at a combination school community-center in a small village near Bagdad, one of eight set up by the Iraqi Government with the advice of a U. N. community-development expert from Egypt.

Based on an address given at the 1956 meeting of the Canadian Conference of Social Work.

malnutrition, wasteful ways of working, and starvation levels of living.

One hundred and eighteen U. N. and Specialized Agency experts, working side by side with the Afghans, have been at the heart of a humane Afghan revolution. These outside workers have brought with them the skills of 28 different lands: the techniques of the Netherlands in setting up aviation services; German know-how in agriculture; South Africa's experience in sheep husbandry; Chinese specialization in silkworm breeding; the knowledge of India's doctors of public health, of Danish obstetricians, and so on.

Some 40 U. N. and Specialized Agency teamworkers are in Afghanistan right now. Ten of the projects they are working on have to do with health, on which WHO is focusing. UNICEF—the U. N. Children's Fund—is associated with 5 of these, and 9 of them are being helped financially by U. N.'s special account for technical assistance.

Afghanistan's valleys, where its cotton and rice crops grow, are notorious breeding places for the anopheles mosquito, carrier of malaria. Half the people in one valley had malaria when WHO surveyed the country's health problems 6 years ago. Since then, with WHO and UNICEF help, the Government has brought this disease under control in the economically important areas of the country. Afghan workers have now been trained to carry on a campaign of complete eradication, which is expected to be achieved in 1959.

While this attack on a mass disease was going on, the Afghan Government turned to WHO for other technical assistance. Unsanitary conditions in communities became another target for joint action. A school for male nurse-sanitarians in Kabul was established in 1953, which trains young men for work in hospitals and community health centers. During 1955, the curriculum for a year's training course for nursing and midwifery helpers was prepared. Seventeen young women, who made the difficult decision to break with the purdah tradition, enrolled. Well-baby, prenatal, and postnatal clinics have now been established in two cities, with UNICEF supplies. A tuberculosis control and training center has been started. To help round out the faculty of medicine at the University of Kabul, WHO has provided visiting professors of anatomy and physiology. It is financing a year's study abroad for an Afghan student of physiology.

Over 100 young Afghan trainees have been enabled to go abroad during the last 5 years under U. N. and Specialized Agency fellowships to study techniques other countries use, not only in public-health projects, but in factories, farming, mines, and aviation. All the time that Afghanistan has been tackling its fundamental health problems, it has been asking for, and getting, technical assistance through the U. N. system for its farmers, herdsmen, miners, and mechanical workers, its schools and its Government agencies.

Afghanistan still has a long way to go before its people can enjoy the personal and economic well-being of people in many other countries. But the leaven of hope is working, and working fast.

The U. N. System

This story of Afghanistan is but one illustration of the impact of international efforts on the well-being of people through the U. N. system. The whole U. N. story is much too vast to encompass here.

Moreover, "international efforts" to improve the health and welfare of people embrace more than the United Nations and its agencies. Such efforts include, too, the activities of individual nations, bilateral programs between nations, and multilateral activities, such as inter-American programs.

I shall consider here, however, only technical assistance through the U. N. system. Let's look briefly at the constellation of units within that system. Within U. N.'s own organization, which is headed by the Secretary General, there is the Economic and Social Council. Within this Council are various functional commissions dealing with social welfare and other matters, among them the Social and Population Commissions.

Both to implement the work of these Commissions and to provide U. N.'s member nations with technical assistance on social and economic problems, the Secretariat has a Department of Economic and Social Affairs, whose activities are supported by U. N.'s general budget. Within this department is the Bureau of Social Affairs, which helps another arm of the Secretariat, the Technical Assistance Administration, to recruit social workers from many countries to serve as advisers in the development of social work programs and schools of social work.

Independent of U. N.'s own organization, but collaborating with it are 10 Specialized Agencies, each with its own budget, staff, and program. Those having the most direct relation to the well-being of families and children are the Food and Agriculture Organization; the United Nations Educational, Scientific, and Cultural Organization; the International Labor Organization; and the World Health Organization.

The United Nations Children's Fund is still a different kind of star within the U. N. galaxy. It was created by U. N.'s first General Assembly in 1946. Its Executive Director reports to U. N.'s Secretary General and to a 26-nation Executive Board. UNICEF raises its own funds from voluntary contributions of governments and from private sources.

Technical assistance to underdeveloped countries received a major boost in 1950 with the launching of an expanded technical-assistance program and the creation of a Technical Assistance Board. The Board is made up of the Secretary General of the U. N. and the Directors General of the Specialized Agencies. Like UNICEF, this program receives voluntary contributions from nations a few of which are not members of U. N. or the Specialized Agencies.

With such funds, the expanded program supplements the budgets which WHO, UNESCO, FAO, ILO, and other Specialized Agencies get on their own account. In addition, it adds to the regular U. N. budget for assistance in economic development, public administration, and social welfare. The program maintains a staff of country coordinators in various spots throughout the world.

Never before have the nations of the world attempted such gigantic tasks as those to which they have dedicated themselves through this instrument of international action.

Some people, conditioned to think in dollars, may see in U. N.'s activities only a gesture when compared with the needs of the disadvantaged people of the world. Last year, total funds available for all kinds of technical assistance through the whole U. N. system—including UNICEF—probably did not exceed $55 million. But when you see, as I have seen:

- hundreds of thousands of children in Pakistan vaccinated against TB at a cost of a penny a dose;

- the nation of Haiti in a very few years almost eradicate yaws, with penicillin that today costs only pennies for each child treated;

- a social-welfare adviser, at a cost of a few thousand dollars, assist the Government of Burma in setting up plans for a comprehensive national social-welfare program;

- a wilderness in India, covering 100,000 acres, cleared of malaria so that 35,000 people can now safely live and produce there, and at an expenditure of 24 cents a person;

- a doctor and a nurse, at a cost of a few thousand dollars, map out an organization of health services for Thailand that will reach out to tens of thousands of children who never before had help in sickness;

In short, when you see the way these U. N.–UNICEF–Specialized Agency dollars multiply themselves over and over again, translating inanimate cash into healthy, hopeful people, then you can be left with little doubt about the far-reaching impact of every dollar and every human ounce of U. N. effort on the bodies and spirits of humanity.

Mutual Aid

This U. N. system of technical assistance is something new in the world. Its help does not come in the garb of a Lady Bountiful, bestowing the castoff things of life on the less fortunate. In the charter that member States of the U. N. signed, they agreed "to take joint and separate action . . . to promote higher standards of living, full employment, and conditions of economic and social progress."

Nor does U. N. technical assistance come as a foil for conquest. U. N. countries have enjoined themselves not to use assistance as a means of foreign economic or political interference in the internal affairs of the receiving nation.

U. N. assistance is unique too in that it operates on the premise that each nation is both a "have" and a "have not" nation. Haiti receives a United States physician to help eradicate yaws, and sends a coffee specialist to work in Ethiopia. The United States in turn is enabled, through WHO, to send a children's dentist to study New Zealand's dental-health program for children. India, which has received many specialists, is now contributing almost 60 of its own for service abroad. Some of the European countries with the most advanced social-welfare programs, as Sweden, Finland, and Great Britain, have received experts in social-casework methods. From U. N.'s worldwide reservoir of know-how, experts have been drawn upon by nearly 100 countries and territories around the world since 1950.

I say "drawn upon," for the direction in which each nation moves in its technological development is determined by its own government. The technical assistance it receives through the U. N. system is likewise determined by itself, within the resources of the U. N. agencies. And for every dollar's worth of help a nation gets, it expends at least one and often two or more of its own.

A Bolivian mother practices dusting her child with DDT as taught her by a Government antityphus team which used DDT provided by UNICEF. The Bolivian Government is also conducting an intensive educational campaign stressing the role of basic cleanliness in reducing infection.

Here, in this vast interlocking system of technical assistance, we have at last true international mutual aid. This presents to professional people around the world—social workers, economists, educators, and health workers of all kinds—opportunities undreamed of by our predecessors. But as the opportunities for internationalizing human welfare have been vastly multiplied, so have its appeals become more urgent.

The Problems

This is vividly apparent at meetings of the Executive Board of UNICEF and at the joint meetings we have with WHO, where the health and welfare problems of the world's children are spread before us. There the millions of dollars we have to work with seem to shrink to farthings when we must decide which of many needs is greatest, which way of helping will count the most. The same kinds of difficult decisions confront the governing groups in WHO, UNESCO, FAO, ILO, and U. N.'s Bureau of Social Affairs and its Technical Assistance Administration.

The picture of want that unrolls before such agencies is vast indeed. Half the world's 2½ billion inhabitants exist on a diet only slightly above starvation level. Throughout vast areas of Asia and the eastern Mediterranean countries, 1 out of every 5 babies born dies in his first year and average life expectancy is about 30 years. Some 600 million people of the world live in malarious areas. Though nearly half of these are at least partially protected, still 2½ million die of malaria each year. TB takes even more lives. As many as 150 million families in underdeveloped areas require more adequate homes in better physical surroundings. Two out of every three people in the world have average cash incomes of less than $200 a year or its equivalent. Of these 2, 1 has less than $50 a year. About 50 percent of mankind can neither read nor write.

The poverty that yokes half our world is like an iron chain whose links are malnutrition, disease, illiteracy, unproductive land, wasteful working methods, unemployment, and early death.

How can this iron chain be broken? Which is the most vulnerable link? Illiteracy may be holding back productivity; but how much education can a people take without better health and food? Can food supplies be increased as rapidly as health is improved?

Such intermeshing questions confront the nations' wants. They confront these international technical-assistance programs. There is no grand strategy for social improvement to guide the nations or U. N. Eventually, let us hope, our social and health scientists will come up with some guidelines and better techniques than we now have to help nations speed their progress with a minimum of hardships along the way.

Meantime these international technical-assistance programs are not waiting for the perfect strategy to emerge. They are forging ahead in courageous and inventive ways. Perhaps the most exciting aspect of this whole crusade is its cooperative nature: cooperation between U. N. units; between U. N. units and the governments of the individual countries aided; between specialists from many countries.

Mass Campaigns

In the massive attacks that are being made on communicable diseases, WHO and UNICEF work hand in hand with the governments in the countries involved. WHO provides the technical know-how; UNICEF, the supplies and equipment; the country does the job.

Malaria-control campaigns have been progressively underway since 1948 in Asia, the eastern Mediter-

An FAO home economist and her assistant, working under U. N.'s Expanded Technical Assistance Program, demonstrate the making of a milk formula to Egyptian fellahin women, as part of the Government's program to improve nutrition.

ranean region, Latin America, and Africa. UNICEF has furnished insecticides, sprayers, and vehicles to more than 50 countries. To win the race with the mosquitoes which may too soon acquire an immunity to DDT, control campaigns are being converted into eradication campaigns in many places, involving the yearly spraying for 4 years of every last dwelling in a malarious area, and a watchful surveillance for 3 years thereafter. WHO estimates that of the 600 million people living in malarious zones, well over 400 million can and should get absolute protection within the next 10 years.

Campaigns against yaws and syphilis are going on in about 25 countries, again with UNICEF providing penicillin, syringes, blood-testing supplies, and transport for the field teams, and WHO providing the experts. If the current pace continues, yaws should disappear as a public-health problem in southeast Asia in another 10 years. A combined WHO-UNICEF-aided attack on TB is reaching millions of children annually. By the end of 1955, 150 million tests had been completed, and 60 million children and young people had been vaccinated with BCG.

Both organizations are at work helping Nigeria attack leprosy. They are demonstrating there what has been found true elsewhere, that after 2 to 3 years of treatment with synthetic sulfone drugs, leprosy can be arrested, perhaps cured.

Trachoma and related eye infections affect 400 million around the world. Victims in many countries are getting WHO-UNICEF treatment. In Taiwan, when the WHO-aided Government program had got rid of trachoma among the school children, it trained them to put ointment into the eyes of their sisters, brothers, and parents at home.

Still another kind of cooperation is UNICEF's supply of equipment to governments that want to establish plants to make their own vaccines and insecticides. An investment by UNICEF of $250,000 in a plant in India, built with U. N. technical assistance in engineering, will make possible the domestic production of supplies of DDT that would cost at least $7 million to buy abroad.

Since its creation 10 years ago, UNICEF has used powdered skim milk as its weapon in helping countries attack malnutrition among children: first, among the children in war-devastated Europe; more recently in protein-poor countries around the world, which last year received some 118 million pounds. Here again UNICEF, with the technical help of FAO, has helped countries expand their own facilities—in this instance for milk processing and conservation. Nine countries in Europe have received equipment for 136 plants, and other areas are now receiving machinery for 30.

In many nutrition projects, UNICEF works principally with FAO—especially to promote milk conservation, supplemental feeding, the production of high-protein foods. FAO sends its technical assistants to countries, at their request, to show how to improve cattle-breeding practices, control animal diseases, improve milk quality, improve range and pasture management. It sends nutritionists to help plan school lunches and show how local foods can contribute to better diets.

Presently, FAO and UNICEF are helping to develop new types of protein foods—fish flour in Chile; a fortified soybean peanut "milk" in Indonesia.

Four agencies—UNESCO, FAO, WHO, and UNICEF—have been helping Honduras develop a rural school program that includes education for the children, health services, school lunches and vegetable gardens, and training of local personnel.

U. N.-associated technicians, including social-welfare advisers, cooperate, too, with non-U. N. experts. U. N., FAO, and UNESCO, since 1951, have contributed specialists to a Joint Latin American Fundamental Education Center in Mexico to which the Organization of American States has also sent experts.

Technical assistance both moves into countries and draws technicians out of countries, not only to help with service programs, but also to assist with regional training courses. FAO and WHO last year provided a course on nutrition in France for workers from Africa. A course on milk-quality control has been held in Rome for European and Near East countries to which UNICEF supplied dairy equipment. Medical and veterinary workers from 23 countries attended a seminar on rabies control which WHO recently held in India.

Training Programs

In all U. N. technical-assistance projects the government of the aided country agrees to continue the work started with international cooperation. To do this, the country must increase its numbers of trained workers. U. N. and its Specialized Agencies are helping in many ingenious ways to multiply rapidly trained workers of various levels of proficiency. Over 6,000 experts have served on U. N. technical missions since 1950, but more than 7,000 fellows have had U. N. help in getting advanced training outside their own countries.

Many nations, however, have problems too vast for the limited number of experts or near-experts it can produce. Auxiliary workers, with varying degrees of training, must be greatly increased.

How WHO, and UNICEF with help from U. N.'s Technical Assistance Administration, go about this varies with the country aided. One way is demonstrated in the Philippines where there have been practically no doctors to serve the villages. There a pyramid plan of maternal and child-welfare services is being built.

At the broad base are the villages, each with some 5,000 to 10,000 inhabitants, and each scheduled to have a health center with a graduate midwife. At the middle will be intermedial health units, in charge of a doctor with public-health experience, to supervise 5 to 10 village health centers. At the top, overseeing the work of 5 to 10 intermedial health units, will be a district center with a varied professional staff and one or more cottage hospitals of 20 to 50 beds each.

When this pilot plan was drawn up in 1954, the goal was to train 2,000 hilots or "granny midwives," enough to attend one-fifth of all deliveries in the Islands. Well over 1,000 have now completed their courses. Each has had at least 12 lessons in such elementary matters as clean hands; how to spot infections; what foods mothers and babies need; when to call for help from the village health center. A hilot's diploma is a midwife kit, provided by UNICEF, which the Government keeps refilled as long as she cooperates with the health centers.

More advanced courses are given to women who have had 6 to 8 years of common schooling. On graduation, they become "qualified midwives" who manage or assist at village health centers and supervise the hilots. Still broader training is given well-educated women to become "health visitors," and carry more general responsibilities. At the top of the training pyramid are standard courses for nurses and nursing supervisors. At all levels of training, UNICEF pays trainees who need it a stipend to cover board, lodgings, and travel.

This pattern of spreading expertness thin to reach as far as possible is being adopted through Asia and Latin America and is getting under way in Africa and the eastern Mediterranean region. UNICEF has provided, or plans to provide, supplies and equipment to over 10,000 maternal and child-welfare centers in some 52 countries.

Not all maternal and child-health training programs are on this elementary level. In many countries, demonstration centers, providing more advanced types of care and treatment permit physicians, nurses, and specialists much more sophisticated learning experiences. The All-India School of Hygiene, at Calcutta, is now staffed and equipped—thanks to WHO and UNICEF—to give comprehensive training in public health and specialized training in maternal and child health, nutrition. and health education.

It is impossible in one paper to give more than a fragment of the infinitely varied story of international cooperation. There is, for instance, the uniquely significant work of UNESCO in helping to free millions of minds of the ignorance, prejudice, and superstition of centuries.

At any one time, some 60 UNESCO missions are at work in 35 to 40 countries helping to improve their educational systems at all levels. Broad programs of fundamental education are currently underway in Ceylon, Iran, and Mexico. An international Institute for Child Development, opened recently by the Thai Government in Bangkok, has a UNESCO-contributed director. Currently UNESCO is inaugurating an international center in Paris to stimulate the production and distribution of films suitable for children aged 8 to 16.

Maury Maverick once said: "We Americans want to pray, think as we please—and eat regular."

This fits free men everywhere. They want to "eat regular," but they also want to believe and think their own way, and not some way imposed on them by outsiders, however benevolent. That does not mean, of course, that they are not open to persuasion. But persuasion is a highly delicate art. It holds in respect the culture and ways of other people and forswears arrogance about one's own ways. It recognizes that not all the values of life are either exportable or importable.

The Art of Helping

To contribute to the economic development and social well-being of the disadvantaged of the world, the thousands of international civil servants who make U. N.'s programs come alive must be people of humility as well as of wisdom; of flexibility as well as of stoutheartedness.

Some, inevitably, are more blessed with these virtues than others. A maternity and child-health official in an Asian country once told me about a United States public-health nurse who had come to give a few days' consultation on organizing rural nursing services. "We cannot start on this project without a committee," she told my friend. "I would appreciate your organizing one for me." My friend at first demurred, since her people are not as passionate about the committee method of working as we are in the United States, but eventually she formed a committee which met each day with the consultant. "We went through with it," my friend said, "because we wanted her advice, and this seemed to be the only way she could give it. But when she was gone, we took her ideas and put them to work in our own way."

However, I know of many more successes than failures in the interpersonal relations between U. N.'s technical assistants and the people with whom they work. For example:

ILO and FAO sent some technical experts to help the Guatemalan Government develop ways of raising the standard of living of its rural people. After studying the situation, they recommended, and the Government agreed, that the little pueblo of Santa Apolonia was the place to start a program. Much of the poverty there was due to lack of water. A dam could transform the soil into good productive land.

The experts approached the chief of the pueblo. "Water," said the chief, "was created to flow in riverbeds, and not to be stopped by dams." But one young man in the village swung opinion the other way. He had been discouraged by the way the "tortuguillas," hard-shelled insects, ate his carrot and potato crops, as they did everyone's and he asked for advice. "Dust the plants with this powder," the FAO worker suggested. Next morning, dead tortuguillas lay all over the ground. Other peasants had the same good luck. The result? The dam was built, and built by the voluntary labor of the young people themselves.

Most changes for social betterment touch the sensitive nerves of human values, relationships, traditions, or beliefs. They should not be undertaken without assurance that the new will not displace something of greater value in the old.

To move with the greatest sensitivity, and always with respect for the dignity of the person served, is the hope of those who direct and carry out the worldwide assistance programs. This is not easy. Their work would benefit greatly from technical assistance from the social scientists who make the folkways of people their life study. I wish we might see far more anthropologists, sociologists, and social workers on all the teams that go out, under either bilateral or United Nations sponsorship, to minister to other people.

Two Priceless Ingredients

Advertisers like to remind us of "the priceless ingredient" in their product. The economic and social progress of an underdeveloped country depends on two priceless ingredients. One is know-how. The other is the opportunity and capacity of people to *choose* the kind of know-how they want and the way they want to put it to work. There is proof enough that if recipients of technical assistance do not participate in this choice in the communities where they live, the benefits of the efforts evaporate.

To help create the conditions out of which such participation can flourish calls for another special kind of technical assistance: the kind that social workers have who are skilled in community organization; the assistance of people skilled—not alone in a specialty such as farming, health care, education, labor, or welfare—but also in human relations, in helping people forge their *own* patterns of community development.

Much remains to be learned about how to provide this sort of assistance in community development, but significant headway is being made in a number of countries. Some of the best progress in this regard is being achieved right now in Afghanistan—which brings this paper back to where it began.

The goals and obstacles confronting communities in their . . .

SEARCH FOR MENTAL HEALTH

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WHAT IS MENTAL HEALTH? Julius Schreiber describes it this way:

"Healthy living—or mental health—means that an individual has found a reasonable measure of peace with himself and with his environment. It means that an individual is able to pursue reasonable, purposeful goals; may use his capacities and talents fruitfully; experiences a sense of security, of belonging, of being respected; has a knowledge that he is liked or loved and wanted; has a sense of self-respect, of self-reliance, and achievement; and, in addition, has learned to respect others, to accept others, to love others, to live fairly and in peace with others."[1]

How then can we achieve a mentally healthy population? We must seek this goal in three ways: by restoring mental health in those who are mentally ill; by protecting people generally against hazards to mental health; and by raising the level of mental health in those who are well.

The first goal, the *restoration of mental health*, is focused on getting rid of a mental illness. The techniques of restoration are applied to those who have already suffered some loss. For the more serious cases they are applied through mental hospitals. Most of these hospitals are conducted under State auspices. Others are Federal hospitals—veterans', Public Health Service hospitals and Armed Forces hospitals. Some are county or municipal hospitals, and some are privately operated hospitals. General hospitals provide some service to severe cases, but they are the chief inpatient resource for cases of neurosis. Large numbers of patients are cared for by outpatient clinics and by private physicians. Very few of these facilities provide all that science has to offer toward restoring mental health.

The second goal, the *protection of mental health*, is also oriented toward mental illness—toward safeguarding people against the hazards that cause mental disorder. Theoretically prevention is applicable to the whole public since everyone is susceptible to some form of mental disorder. But some people live in more hazardous situations—as do young children and migrants—and consequently are appropriate subjects for a more concentrated preventive effort. Science has more to offer toward prevention than, unfortunately, is now being used. Public-health departments and public-health-nursing agencies are our first line of defense, but other agencies, such as those concerned with the restoration of mental health and those designed to elevate the functioning level of well persons, are also in positions to prevent mental illness.

The third goal, the *elevation of mental health*—positive mental health—is not oriented toward illness nor toward the prevention of illness. Rather it has to do with the unrealized potential of the well. The talents or capacities of persons have, as a rule, far greater potential for development and use than has been achieved. The elevation of mental health is, therefore, focused upon the whole population—just as are our schools. In fact the school is the chief instrumentality of a positive mental-health program. The family, the church, the Armed Forces, the job, and recreation are also important agents. All of these encounter, incidental to their main functions, opportunities to treat disorders and to guard against them.

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[1] Schreiber, Julius: Mental health flowers in democratic soil. Mental Health Bulletin, March-April 1951. Chicago: Illinois Society for Mental Hygiene.

Obviously, these approaches to mental health are interdependent and inseparable. Each has a different primary orientation, but also incidental opportunities to support progress toward the other goals. Each is apt to get leads to its primary task from the experience of the other. A community which allows its agencies to go each in its own path without regard for the other is failing to do all that could be done in behalf of mental health. Most communities fail in this respect.

Whether the search for mental health is through restoration, protection, or elevation, it should be scientifically based insofar as science has something to offer. Admittedly there are still vast areas of darkness in which no scientific guides to action have been found, and a practical program must fill in these gaps by common sense, guesses, or other nonscientific procedures. But this does not warrant the neglect of that which is known.

The scientific approach to mental health is especially complicated by the great diversity of mental illnesses and the complexity of causation, including the multiplicity of causes. Few generalizations are possible. There are over a hundred different conditions of which mental disorder is an expression. Moreover, good mental health shows itself in a variety of ways in different cultures. Behavior that would signify mental disorder in one culture may evidence a high degree of mental health in another.

Types of Prevention

Because of this diversity preventive efforts are easily misguided. In fact the term prevention is used indiscriminately for a quite different set of goals and processes. There are really four types of preventive work: (1) absolute prevention; (2) presumptive prevention; (3) relative prevention; (4) relapse prevention.

Absolute prevention covers those processes that are so well validated scientifically that if one has the potential victim well under control he can assure protection against the disorder. These preventive procedures are very simple and at the same time quite specific. With the person under control one can surely safeguard him against alcoholic mental disorders by removing access to alcohol or against mental disorders of pellagra by adding a niacin supplement to the diet. He can be assured of a high degree of protection against paresis by intensive early treatment of syphilis, or be protected from traumatic psychoses by protection against head injuries.

But such absolute preventive measures apply to only a small percentage of mental ills, about 8 or 9 percent of the cases entering our mental hospitals. Moreover, these preventable ills are often the secondary manifestations of a more deep-seated ill which is in itself not so assuredly preventable. The urge to solve life's problems with alcohol is a different disorder from that which results from drinking alcohol. Pellagra is the result of food habits which often resist change. Sexual promiscuity, which has much to do with the transmission of syphilis, is mentally a quite separate disorder from paresis. Accident proneness is a completely different affliction from the mental illness of brain injury. These underlying disorders are more akin to the neuroses. For these the preventive effort is in the area of presumptive prevention.

Presumptive prevention is much less certain of success than absolute prevention. Still it is the most frequent form of preventive mental-health work. It is behind most of the efforts in parent education and guides to wholesome living; it is the theme of innumerable pamphlets, films, and lectures.

Presumptive prevention is based upon the fact that studies of those who develop mental disorders tend to show early life experiences, especially in childhood, which seem to be related to the disorder's origin. Sometimes this experience has been a deficiency of parental affection, sometimes a sibling rivalry, sometimes a strict constraint of the child's normal activities, sometimes an unfortunate sexual experience.

Most of the case studies which have revealed these earlier adverse experiences have been made in regard to persons with neurosis or character disorder, psychoanalysis having been especially revealing. But in the efforts to prevent mental disorder by sparing children these hazards, the goal is broader, including the forestalling not only of neuroses, but also of schizophrenia, depressions, manic-depressive psychoses, and several other forms of mental deviation.

To expect the factors underlying the neuroses to apply to other disorders may seem unreasonable, but the illogic is less than it appears. There is strong evidence that many of the more severe disorders are the products of a multiplicity of factors, no one completely determinative. Any factor may be the last straw in the pathogenic combination, and conversely the removal of any factor may give sufficient relief to reverse the deviant tendency and restore a degree of normality. There is good reason to believe that psychological forces are a part of this morbid combination and that the removal of the psychological burden may be enough to turn the tide toward prevention or cure. This form of prevention, therefore, even though uncertain, is fully justified. In fact its neglect falls into the category of failure to apply that which science has to offer.

The neglect of presumptive prevention is also unfortunate in slowing scientific progress, since science advances through the application of presumptive measures. However, science does not advance if the presumptive is not recognized for what it is, but instead is credited with undue certainty. This obscures the need for more research. For this reason the different forms of prevention need to be identified.

Relative prevention is prevention only in the sense that by treating a problem early it may be prevented from becoming worse. On this basis, child-guidance clinics have been referred to as preventive agencies. There is no doubt about their effectiveness or the validity of their goals. They have, furthermore, built up a sizable body of knowledge and technique bearing on the treatment of children's behavior disorders. But there is little evidence that the disorders seen in a child-guidance clinic would if untreated progress into severe mental illness. These services are so worthwhile within their demonstrated values that there is no need to overstate their goals in order to justify their existence.

Relapse prevention is very similar to presumptive prevention. It is the effort to prevent a recurrence of mental illness in a patient who has been treated to the point of recovery. It is based on the fact that the clinical work entailed in bringing a patient through a mental illness reveals his special sensitivities and susceptibilities and suggests specific ways in which he can be protected from relapse. It is much more custom made than is presumptive prevention, yet is cut from the same cloth.

Reasons for Failure

These four forms of preventive effort are all good and desirable within their limits and are appropriate components in a community mental-health program. But most communities are entirely lacking in the last three and are not very well equipped in facilities for absolute prevention, which lie for the most part (except for alcoholism) outside the psychiatric and mental-health field and more in the area of general public health.

Why this discrepancy between what science has to offer and what is made available to the public? The answers are varied but, reduced to basic attackable form, the factors fall into six categories: 1) citizen immaturity; 2) professional tradition; 3) agency isolation; 4) mass service; 5) gaps in science; 6) lack of money. A brief inspection of each of these factors may clarify their importance.

Citizen immaturity is probably the most consistent factor behind our lag in services. In a democracy the government is the cititzen, who chooses his agents of government, and who carries the ultimate responsibility for service. He cannot assign or relinquish that responsibility. He may choose ineffective, static, or dishonest agents, but he cannot excuse himself thereby. He may leave it to others to design and initiate lines of progress in public or private pathfinding services, but this is his failure. If he carries his responsibility by proxy—as perforce he is bound to do in such a complex of public services as now characterize the American community—he is bound by the adequacy of his proxy. There are available to him as proxies voluntary citizen organizations such as mental-health associations to help him to plan, consolidate effort, and limit it strategically.

In the United States there is no place for the excuse—"I am not political" or "I am just one person." In every community there is a place for the citizen to get into action. He can at least attend the meetings of his school board. He can volunteer in mental-health agencies. He can serve on local committees. By doing these things he matures as a citizen.

Professional tradition appears as a block often in unexpected ways and places. Why do professional people practice exclusively in an office rather than in the patient's home? Why do many physicians minimize the personal and situational problems of their patients? Why do obvious sore spots in a community continue unchanged even though fully recognized by the profession? Why are architectural plans for schools, hospitals, and clinics so far out of line with the functions to be performed? Tradition lays a heavy hand on progress at many points even after some student of the field has shown how expensive and handicapping it can be.

Agency isolation is a major force in blocking progress. Isolation may be abetted by geographic remoteness, but it may also exist right in the heart of a city. Geographic distances simply make isolation easier. Essentially isolation results from the reluctance to enter into "entangling alliances." It makes administration easier even if less productive. Administrative ease, in fact, also appears in many other forms of obstruction.

Isolation is at work when an agency tries to be an omnibus service—to include every need within itself, even though it never can fill them all and thus must remain defective. Every community agency is only a part of service and is dependent on the others. Schools cannot operate at their best if the local public-health services are poor, nor can the latter carry on effective health education without the former. Isolation becomes a self-crippling device. It can be seen in competition between agencies for the tax dollar. Improvement elsewhere in the community may often be a prerequisite to progress within one's own agency.

Mass service prohibits the application of much that science has to offer. It prevents the schools from individualizing their programs sufficiently to permit the child to adjust to the curriculum. Thus it produces failure and retardation. It accounts for "unreachable" labels on people whom the agency finds recalcitrant. To a degree mass service is apparently unavoidable, but administration and programing often use it as an excuse for shortcomings which need not be tolerated. A periodic appraisal of services is apt to reveal them.

Gaps in science tie our hands at every turn. There is scarcely a case need or a community deficiency that does not call forth the frustrating thought, "if we only knew more about this." Only research can release us. But research lags not only because of deficient funds and intentions. Another reason is blind faith—faith in a procedure as the right answer although it has not been tested by research. Related to this is the failure to distinguish between a theory or hypothesis and a scientifically validated finding. A practice based upon a school of thought closed to scientific critique is technically dwarfing.

Lack of money may impede progress, but so may a defeatist idea of poverty. There is certainly a real difference among communities both in the fullness of their public coffers and in the financial reserves of their private citizens, and these differences have a bearing on the use that is made of what science has to offer. But communities of equal per capita wealth show great discrepancies in provisions and in their attitude toward what they can afford. Most communities of modest means use the excuse of poverty beyond its legitimate limits. While the ratio of income between the most affluent state and the least is about 2 to 1, the expenditures for mental health are in the order of 6 or 7 to 1. The discrepancy is the measure of the alibi.

Ways to Progress

How can these obstacles to progress be discovered? The answer may be found in a common practice in industry, *the study of failure.* Failure has tremendous value as a lead to advance if it is accepted as a stage in progress rather than a reprehensible quality which must be hidden. Industry could not survive without a careful study of its failures. The anxiety created by failure in human services, however, causes its incidence to be swept under the carpet where it cannot be seen and, of course, cannot be analyzed. Every agency set up to help people with their problems is in a position to discover in what ways the community has failed its citizens. Every case of mental illness figuratively points to these failures, yet these signs go unheeded until the failure becomes too glaring to be ignored.

Specifically every case tells us one or more of the following things:

1. Some of those who have tried to help have had misconceptions of the problem or its solution or downright lack of knowledge.

2. In certain respects the community facilities have been deficient. This may be such things as inadequate recreation facilities, special classes for deviant school children, or probation staff in the court.

3. Gaps exist in scientific and technical knowledge.

There are ways to deal with all three of these deficiencies. First, dealing with them must be considered as important a part of one's job as working to help the case that gave the clue to the defect. The problem must be somebody's business. Second, a strategy of attack must be designed, followed, and recorded. Progress sometimes takes place by haphazard effort, but such effort is generally misleading and expensive.

Social workers in St. Paul's experiment in family-centered treatment approach . . .

CASEWORK AS A PARTNERSHIP

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THIS IS a report of an attempt to make the purposes and methods of casework clearer to the people served. To do this, social workers have tried to take reluctant families into partnership with casework, to develop in them a sense of full collaboration. The social workers bring to the partnership some knowledge of interpersonal skills; the families bring their views on how social work can be more useful to them and to others. No descriptive blanket can cover these 140 of St. Paul's most seriously disorganized families. Nevertheless, a few of their common characteristics indicate that others like them can be found in any town. They do not behave as the rest of us wish they would. They are in conflict with authority. The neglect and delinquency of their children force the community to take responsibility for them.

Here we see people who reflect in their attitudes toward themselves the negative attitudes of others toward them. The father whose family has been on relief many years has shrunk in self-esteem. With this has come a sloughing off of responsibility. The mother has not had a chance to learn a full mothering role and has not been able to do well without her husband's active support. The children have either become pawns in the conflict between parents or their needs have been overshadowed by the pressures impinging on the family.

Outstandingly characteristic is the psychological distance that separates these families from the rest of the community. *It is a distance of distrust.* Eight social workers and their supervisors in the St. Paul family-centered project are trying to lessen this distance.

These workers volunteered to take part. They did so because a research study in St. Paul had fixed community attention on the chronically troublesome families who had resisted helping efforts.[1] Five local agencies contributed staff, workers, and supervisors, to a cooperative service. Two additional agencies have recently come in for a 3-year extension of the project.

Work with the 140 families began on July 1, 1954. They were selected on the basis of serious behavior problems damaging to children, and failure to respond to earlier treatment attempts.

Our project is called family-centered because one caseworker addresses himself to the social needs of the whole family. He serves as a bridge between the family and the other services it may require, and takes responsibility for a sustained, coordinated plan of treatment based on a family diagnosis. Previous treatment efforts with resistive families have been sporadic, fragmentary, and oriented to crisis or individual.

The social workers who volunteered for participation knew they were to become part of a cooperative research project in casework method. They knew they were expected to develop adaptations of method acceptable and useful to distrustful families. They knew they would have to test out their own ideas of practice and would share with the research arm of the project the job of analysis, definition, and evaluation of method. They had a valuable sense of support from a well-developed community interest.

Preparation

Most of us were afraid to intrude on people who had not asked for our help. So we met in regular weekly seminars to fortify each other. These seminars are still going on. The County Welfare Board workers, with more experience in protective service, helped the rest of us with such practical matters as what to say in the first letter or telephone call.

We studied the old records carefully and got the most detailed school reports we could secure. This strengthened our opening position because we had to speak the first lines, and the lines had to make our purpose understood.

The Beginnings of Partnership

In the old records we noticed the sense of bitterness the families had developed about always being on the receiving end of negative community attention. So from the start of the seminars we began searching for ways in which the families could feel more a part of the community by giving something of value back.

This is how we hit on the word "partnership." The term implies reciprocity and suits our psychological purposes better than the usual "worker-client relationship" where the worker is seen as the helping person and the family as recipient.

We wanted to get out of the position of omnipotence in which distrustful people place figures they associate with authority. We wanted to be working associates of the families. We wanted them to have a sense of proprietorship about our project.

We liked the concept of partnership because we wanted our families to have a sense of being "in on the deal." We did not go out to do things *to* or *for* the families but to stimulate their own planning and action. We wanted them to know what we saw as needing change in order to draw from them ideas of what they wanted for themselves and to get them started in thinking about steps they might take to pull their families together.

At first we had a common tendency to fluff our opening lines. We found it hard to say that we knew the children were stealing, the parents drinking, or to define other serious behavior problems. We thought we were protecting the families by shielding them from the hard facts of why they had been selected for service. As we developed more clarity, however, we could see that avoidance of direct and full sharing of information emerged from a desire to protect ourselves from a hostile response or from being shut out. Gradually we came to realize that we had to behave in a way that would elicit the family's trust—to let them know the full meaning of our concern.

What happened in the W. family illustrates how in one case an effective family-worker partnership was eventually achieved after some groping by the worker. All six children of this family had been removed from their own home by the police. A finding of neglect had been made by the court. Eight months later the parents came into the office for their first appointment after the worker had made numerous attempts to see them. The interview opens on a belligerent note:

> Mr. W. arrived first and had obviously braced himself for the interview at a tavern . . . talked loudly and at a great rate, launching an immediate assault on me about his dissatisfaction with the home that Michael is placed in. . . . Mrs. W. arrived at this point. . . . She immediately began scolding Mr. W. who had . . . [failed] to met her. . . .
>
> Mr. W. then suddenly demanded "when are we going to get the kids back?" . . . I indicated I understood that he felt anxious to have them back, and maybe angry that somebody else was taking care of them. I said they could have the children back when they had a house and other things they needed to run it. I explained I knew they had been making attempts to get housing. Mr. W. said they chased up every ad in the paper. If the place was not a dump, they were rejected by the landlord because they have so many children. . . . He said that . . . they had been doing a lot of fighting that they didn't use to do. Further discussion of this revealed that their life now is totally different from when they had the children and that they are reacting to this change . . .
>
> At this point Mr. W. opened up a barrage on the question of previous efforts made by workers to help them budget. . . .

The worker then proceeded to get himself sidetracked in questions of budgeting, debts, and the like. He did not once indicate that the family's problem was not entirely a question of setting up a good house nor refer to the facts he knew about their previous neglect of the children. He failed to explain his purpose. The result was that the W.'s did not keep their next four appointments. Later in a home visit the worker did begin to treat the family as a partner, getting down to the basis of his concern. He then recorded:

> I shared with the W.'s the fact that their public-housing application had not been accepted and that their leaving the children alone and their trouble with the neighbors had been taken into consideration in this. I told them I knew what the situation was when the children were originally removed from their care. The W.'s were defensive . . . They said they had never left the children alone except occasionally to go shopping . . . I disagreed here and gave the facts from the police report on the condition of the children. Mr. W. at this point became very angry, directing this not at me, but at the "damned nosy neighbors" . . . Mrs. W., on the other hand, gave a little, saying that in their previous places the children tramped all over her, she was unable to run the house in an orderly manner, clothes were

all over the place, the children covered the furniture with dirt, and she felt helpless. She felt that this was in part attributable to the "dumps" in which they always lived.[2]

In the next interview the worker talked about what was happening to the children as a result of living in uncertainty caused by broken parental promises about their return. When told of the misbehavior of the father's favorite son, Mr. W. said things had gone far enough. Within a month he found a house and brought four children home.

We in the project believe in sharing our social diagnostic impressions with the families we serve. The family must hear about what we have seen in order to correct our impressions. The family must hear about what we want in order to define what they want for themselves and their children. In this give-and-take the members of the partnership can clarify what they are doing together and decide on a plan of action.

Such directness is not directiveness or manipulation. It is treating the client as a full associate and letting him know our views on the necessity of and possibilities for change.

Analysis of Change

As changes occur, small though they may be, we believe that their analysis is of great value. This is a sound course for the partnership to pursue regardless of what the family has achieved. I am referring here to positive change. Negative change or no movement needs as much scrutiny but is more likely to get it. Casework has addressed itself more fully to why people fail than why they succeed. This is an emphasis inherent in our assignment and we need not feel apologetic about it, but we must look more intently at any gains a family is able to make.

Families have a common tendency to forget the depth and extent of a trouble spot once they have moved away from it. Therefore the caseworker has to refresh their memories of what this was so that they can see clearly how they have moved. If a child who was persistently truant last year has been attending school regularly for a month, how did the parents accomplish this? Did they work on it together? Who did what? Who said what? How did the boy respond? Can this achievement be extended to the other children?

If a family analyzes its achievement with the worker's help, the result may be not only a consolidation of the gain itself, but an increasing stimulus to responsibility and an enhanced self-value. Gain itself is less important than the feeling of "I did it." This is why we have held up each speck of achievement for the family to see.

This method has to be used realistically. Praise can have a tinge of condescension. We prefer recognition. We help our partners recognize their strengths by reviewing what they have accomplished. The "how" of accomplishment adds to their understanding. Gains must be tied in with ongoing problems, so that people can see how their efforts can be extended to other areas.

We have been holding periodic "review sessions" with families as a way of consolidating gains and furnishing a stimulus toward further change. Here is an illustration:

> After 6 months of work with the P. family, I suggested that they review what had been accomplished. . . . Mr. P. reported that he had paid over $300 on his debts since he had begun a debt-adjustment plan. Even though he had not been working full time, he paid a few dollars each week. . . . When asked how he had been able to do this in view of his previous procrastination, he said that he had been in the habit of thinking the world owed him a living but now realized that he and no one else was going to be responsible for his family. Although his debts had been reduced, he was very discouraged. . . . I acknowledged that the family had lived on less than the public-assistance budget during most of the winter and said that it showed their determination to continue their plan. I also pointed up the positive fact that Mr. P. had been employed for the same company all winter even though he had not worked full time. . . .
>
> The P.'s had recently moved to an old rundown house, on which Mr. P. was making extensive repairs. He was discouraged about the progress of this work. . . . His wife commented that . . . she was willing to undergo temporary sacrifices as long as she saw her husband working in the direction of better things for the family. I commented that she had certainly been willing to share the responsibility by budgeting food and clothing costs to a minimum. She seemed glad to do this, and there were none of her previous nagging tones. . . . Although Mr. P. minimized his own efforts on the house at first, gradually he admitted to quite a long list of accomplishments. . . . My interest encouraged him to offer to show me the rest of the house.
>
> I then pointed out that the P.'s accomplishments were often overshadowed by the immensity of the tasks they set for themselves. I also tried to help them take a better look at where they were going. . . . Maybe their youngsters would wear old clothes for a while but wasn't it worth it if it was in the interest of a better home for them? At the conclusion of the interview I felt the parents had a new view of the task they had undertaken, and a slightly greater feeling of self-esteem.[3]

In our concept of partnership we have in mind *an active nudging of the ego*—a pointing out and a calling up of strengths. We look for areas of health, for good spots of performance, and hold them up to be seen and better understood as values. By pointing out these to the families we reveal both our respect and our expectations. This, more than passive acceptance, seems to do something positive to their self-esteem.

Partnership in Evaluation

The review sessions for scrutiny of achievement gave us an idea of another way to make a bid for the family's partnership. A year ago we faced the research problem of evaluating the effectiveness of the project's first 18 months of work. It occurred to us to ask the families themselves about this. Who is in a better position to say whether their condition is better or worse? Accordingly, the caseworkers talked over with their families the way that they had been functioning 18 months previously. Then they asked two questions: 1) How does the family think it has changed? 2) What has the worker said or done which has had a bearing on this?

We asked Mr. W. to write his evaluation. The caseworker gave him a few topical headings and here is what Mr. W. wrote:

> Well it's been changed for the good in the last year. We had to crowd ourselves a little but it sure has been worth it. My wife takes a better interest in the housework and the children and also we talk over things we never used to. . . . I seem to enjoy being with my children more. . . .
>
> Health: As of now the children are all in good health and they always were.
>
> Care of Children: The living conditions are much better than what we have been living in. . . . So it's much easier to take care of the children.
>
> Financial Circumstances: We've just lately realized the importance of keeping your credit in good standing even if you can't take advantage of it. . . . It's coming slow, but I still am trying to do the best I can.
>
> As a Family United: As we've had the children boarded out a few times we seemed to have missed them more and we have talked over things to find out why we let things get messed up the way they did. But as of now, that we are all together, we are all trying to cooperate and get along and help one another to improve things and not make just one person responsible. Now that we have more space the children can enjoy a little privacy and so can my wife and I. That way we don't get in each other's way all the time and . . . can enjoy being together as a family. . . .
>
> What Has the Worker Said or Done That Might Have Had Something To Do With This? Well, you yourself, Mr. ———, can really get the most credit for bringing all this good fortune to us. You have been more understanding and patient than the average person. It's been an up-and-down deal all the way through, but I think you have had a lot to do with our success in being together as a family. I haven't been as talkative as my wife, but as you know, I'm gradually awakening to the fact that it's not only for my own good, but for my family as well. You've explained a lot of things to us which were to our benefit. . . .

From the viewpoint of evaluative research this method has its bias, as does every approach. Apparently Mr. W. needs to forget the circumstances under which the children were placed. The method will require much additional work before being fully useful. Next year we plan to use three independent judgments: the family's, the caseworker's, and the research analyst's. These can be buttressed or refuted by recorded data on school attendance, arrests, violation of probation, and the like.

We also see this method as a way for families to make a contribution to research, and we feel it important to tell them that this is what they are doing. We have found that this has enhanced their feeling of partnership.

Research, however, should not be carried on irrespective of the casework needs. In the W. case, for example, the worker had an immediate purpose in asking Mr. W. to write the evaluation. Mrs. W. had tended to dominate all the discussions except for occasional outbursts from Mr. W. when fortified with alcohol. His sitting down to think and write about his role in the family produced a change: his participation became much greater in the joint interviews. This stocktaking process apparently added to his understanding.

In our seminars we have argued the advantages of written or verbal statements, structured or open evaluations. We have found that the form must be selected in accordance with the needs and abilities of the people involved. Originally we assumed that only our sophisticated families would be able to write, yet we have often found more insight in poorly written evaluations.

We have a few suggestions for caseworkers who may wish to try this method: Don't try to spring it on the family in a crisis when they need to talk about an urgent matter. Don't expect them to ad lib without a chance to mull over the topics. A few headings covering the major areas of family social functioning have to be set up as guideposts.

Teaching Material

This practice of bringing families into evaluation suggested another way for them to give something of value to the project. They could contribute teaching material for the social-work profession by telling what the worker said or did that had any bearing on their gains or losses. A number of our families have already responded to the idea of helping us to give better service to others like themselves and have given permission for their letters to be used for teaching purposes.

We feel sure that the families will produce material of value to our profession *for while we are observing them they are also making very specific observations of us.* One mother wrote:

> When the worker first came to offer help, several things ran through my mind. I thought, "Was this a clever ruse to take the boys?" or did he intend to try to persuade me that I should return to ——— (a mental hospital)? I thought his coming would have some adverse effect upon my life.
>
> He made one statement, however, that struck a pleasant chord. He said, "We are interested in helping the entire family in the home." I had been in the offices of psychiatrists and of other agencies. They were all the same. Their chief interest had been to take the children or myself out of the home. I had never been summoned into any office to hear those long-hoped for words, "We are going to try to help you stay together."
>
> There have been some very favorable changes of approach. One is that of meeting the problems in the home. I have never been able to get over the dread I had of offices. Another is the feeling of optimism woven all through our talks. Also helpful is proper comparison with the past. Sincere compliments have encouraged us to keep pressing ahead. During the last months, I not only have learned that I can trust Family Service, but I have more faith in my own ability. . . .
>
> . . . There is yet much to do and many battles to be won but I have been given the will to try.

Here are some pieces of other families' observations on casework method: "Gave supervision of the boys to us, which gave my husband a responsibility." "It's best to help the parents regarding the children's problems than to have outsiders help them." "You trusted me to take care of the kids." "Social workers have been mostly critical of parents and mostly interested in the children."

The families can also tell us how they would like social workers to behave or not to behave, the things they find useful in our practice, and the things they find either useless or destructive. Here are some comments from letters and case records: "He don't act like he has training. He forgets." "Most workers talked too fast for Mr. C. and he appreciated my slowing down." "You sorted out and gave ideas of what I could do."

"Bugs" in the Technique

These fragmentary statements are the results of a technique which is only in a beginning stage and which has some "bugs" still to be removed. We see three: a) a tendency for the family to throw a posy to the worker; b) a possibility of the workers' putting words in the families' mouths; c) the families' lack of recollection of things past.

From the research objective the tendency to compliment might be eliminated by having another person work with the family on the evaluation. We plan to change caseworkers for our followup studies on closed cases. However, this strategy will not advance our casework objectives. Certain workers have already shown the way to a partial solution by carefully explaining that they want the family's specific description of the caseworker's behavior, rather than approval or condemnation. They are able to illustrate what they mean by telling how in their work they describe a family not as good or bad but in terms of what they do. I believe improvement in this area can be accelerated once we have been able to demonstrate to our families the usefulness of their reports.

Asking the families to write their evaluations helps to avoid the danger of putting words into their mouths. There is another striking advantage in a written evaluation. It intensifies thought process and therefore has a greater potential for insight and understanding. The choice of who shall do the writing, when it shall be done, and what form it should be in has to be made in relation to specific casework needs. Some persons will not be able to express themselves in writing at all.

The third problem, poor memory, may be the most serious. We all tend to forget a trouble spot once we have moved away from it. Moreover, because family development does not follow a steady course what we get in an evaluation at any one time is apt to be chiefly a reflection of the current crisis. The family has no case record, as does the social worker, to help in its review and analysis.

The seminar discussions on this difficulty led us back into a controversial issue which we had dealt with many times in the past—the possibility of sharing case-record material with our partners. We originally saw this as harmful. It would be, if we shared every shadowy impression, every hypothesis about unconscious factors. However, we meant to share only those factors which our partners could use.

We began by showing families first drafts of reports we were writing to the court about them when such reports were required. Court experiences had been confusing to most of the families, many of whom felt that social workers and the court had conspired against them. They had felt threatened by the social worker's report because they did not know its content. In showing the families our draft reports we invited comment and possible revision. If we did not agree with their suggestions, we stuck by our guns but took pains to explain our position clearly.

Now we are going to experiment with some sharing of case histories. We have begun by leaving with one family a pencil carbon covering the main points of each visit. This will provide a guideline for the family's memory of the changes it has achieved. The caseworker plans to follow this up with an exchange of views with the family about what has taken place in the interviews.

And then, why shouldn't recording be a joint product? We are not always sure of our diagnostic estimates. Wouldn't it help us to have a different perspective? After all, social diagnosis is essentially a plan of action and, if the families aren't completely in on the planning, how can they act?

We, of course, still have some doubt about using recording as an instrument of partnership and are proceeding slowly and carefully. However, our seminars have revealed that most of the difficulties in this type of recording have been certain practical problems it presents for the caseworkers. Here as elsewhere we found that most of the resistance to change was in ourselves.

The Spirit of Partnership

Our research findings suggest that the strongest factor in social-work performance may not have been casework skill, but the sense of complete investment made by the workers and caught by the families, for in some instances improvement has taken place even where the casework was on the clumsy side. Our caseworkers give a strong impression of this "going all out to" spirit. Perhaps their group experience as generated in the seminars has intensified it. However, while they have drawn support from many sources, I think most of the motivation to keep going, to try harder, came from the response of their partners.

One appraiser of the project has noted a substantial shift toward simplification in the vocabulary of the workers. She believes this reflects their wish to be better understood by the families. She also notices a growing freedom to acknowledge mistakes to the families. These admissions of error have helped us to get out of some stalemates.

Space won't permit me to give here the full research findings on the varying response of our partners. However, I shall mention the one item of most change: 64 percent of the families were found to be making a greater use of community resources. This suggests that we are approaching one important objective, that of bringing the families closer to the community. They are getting along better with schools, clinics, and other agencies—the distance of distrust has been shortened. We think the sense of partnership has had most to do with this.

Partnership has a corollary in the feeling of proprietorship about "our project" on the part of some families. One woman called up recently to complain angrily about a newspaper article which took a patronizing approach to a fictitious multiproblem family in a story about the project. She objected because of its lack of dignity and said she had told her friends she was a part of this research project and she did not like to see it publicized in a way which did not give a fair picture of what the families in it were trying to do.

This is the sense of proprietorship we had been hoping to build. Other families are offering to report their experience to our citizens' advisory group. Our plan is to have these reports used as the basis for planning better community services.

Our project has not done as well as we would like with certain phases of social action. However, we see this as an inherent part of the caseworker's job. The caseworker is a bridge between family and community, bringing the reluctant family closer to the community, and working for a better community adjustment to its multiproblem families.

While this is a report of what a few social workers have learned from their family partners, its main purpose is not to tell what they did. Its purpose is rather to urge others to invent and test out new or adapted methods of casework practice. Social work is a young profession. It needs experimentation for growth. There is still much to be learned about social behavior—there is still little that we really know about causation.

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[1] Bradley Buell and Associates: Community planning for human services. Columbia University Press, New York. 1952.

[2] Unpublished case material by John Crane, Family Service of St. Paul.

[3] Unpublished case material by Audrey Selander, Ramsey County (Minn.) Welfare Board.

IF INSTITUTIONAL TREATMENT IS TO SUCCEED

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TODAY a changed but increasingly clear conception of the place of children's institutions in the general field of child welfare is emerging. At one time institutions were considered the only place for children who had to be removed from their own homes. Even while foster-family programs were being developed in some parts of the country, in others institutions provided the only foster care available. Then came a period when everyone was sure that the institutions were disappearing, that they had no place in the field of child care. Now, however, the pendulum has settled back to a midpoint where important, though different, roles are afforded to both boarding-home and institutional care.

The function of the institution has changed considerably during the past 25 years. In general an institution is no longer regarded as a good place for children to grow up in or to spend any time in at all while very young. Public-assistance programs, adoption services, family casework, foster-family placement have made it unnecessary for children to be sent into group care because they are orphans or because of destitution. Therefore, institutional populations are less than they used to be but the children in them are for the most part children with serious emotional problems. They are youngsters with backgrounds of severe social disorganization, from families which have broken down emotionally if not physically, who have been through long periods of injurious experiences. They are children in need of skillfully applied help to repair personality damage and to prepare them for emotionally healthy adulthood. They usually stay in the institution for 1 to 3 years and then return to their own families or go into foster families.

Thus, the use of an institution in child welfare today is as a treatment resource similar to a period of hospitalization. Most institutions are attempting to develop programs and staff to carry out this function. Some have transformed themselves into what are called residential-treatment centers, with large staffs of psychiatrists, psychologists, social workers, educators, and other specialists. Unfortunately, others have made little effort to meet the needs of today's children and are still operating as they did 50 years ago.

The vast majority of children's institutions are at neither extreme. They have not changed completely into residential-treatment centers, but they have developed service to meet the needs of children with mild or moderate emotional disturbance. Competent, trained social-casework staffs, improved cottage or group-care personnel, rich programs of activities are considered essentials. Psychiatric consultation and service are being secured through community clinics if not available in the institution's own program.

The points to be made in this article are based on the assumption that the decisions that the child must leave his own home and that institutional care rather than some other form of foster care is best for him have been reached through careful diagnostic study of the child, his family, and all other pertinent factors.

The Institutional Community

No one institution can serve all types of children. Each must develop a program and atmosphere suited to the needs of certain types of children. The freedom allowed in one institution means that it is unsuitable for the child who requires close supervision and protection from the community. On the other hand, the closely supervised, restrictive program of another will not help the child who can use freedom well and who needs opportunities to have community contacts and even to make mistakes in them. Again an institution's school program may determine its intake to some extent. Going to the public schools

A summer afternoon in a home for dependent children. Opportunities for fun provide a healthy background for a program focused on the needs of each individual child, with return to a family setting as the eventual goal.

may be best for many children who live in institutions, but others who cannot get along with teachers or pupils may need an institution operating its own educational program. If a child needs the kind of care a foster family can provide, no institution can really help him.

An institution is a small community. The makeup of the community greatly influences its success or failure. Therefore, the administrator must be constantly concerned about whether its population consists of children who need the type of experience the institution can offer and whether the behavior problems these children present are in proper balance. This kind of balance is important in preventing any destructive attitude from too strongly pervading the atmosphere. If all the children have engaged excessively in stealing then it becomes almost impossible for the institution to prevent an atmosphere from developing in which stealing is an accepted mode of behavior. If all or even a large number of children have temper tantrums, social pressure against such behavior does not exist.

One of the tools of a group-care program is group pressure. Most institutions can accept some children who steal, because the majority of the youngsters under care do not do so and therefore the group pressures are against stealing. The same policy applies to temper tantrums or any other type of behavior. When a balance is maintained no one form of behavior becomes the controlling factor in the group attitude. Therefore, an institution may accept a child with certain behavior tendencies today but next week decide against taking another with the same behavior pattern because he might overweight the group pressure in a destructive direction. The problem of achieving proper balance cannot be solved through a mathematical formula but only through the administration's having knowledge of individual children and a "feel" of the group.

Referral and Intake

An institution cannot and should not operate in a vacuum. As one phase of a general child-welfare program it has much to offer but at the same time it is almost completely dependent on other agencies, particularly the referring agencies, in making its services successful.

Without cooperative effort between the staffs of the institution and the referral agency the child will not get the assistance he needs in the group-care program. Caring for a child away from his own home is a complicated task. No one agency or profession can do it alone. Agencies and institutions and the various types of personnel involved must be free and honest in their communications if the children are to have effective service.

If an institution is given a social history of the child at the time of referral, it has a basis for forming an opinion as to whether or not it can benefit the child at this time and hence for making a decision for or against acceptance. An institution which accepts a child who does not belong in the program, is doing a disservice both to the referring agency and to the child. To place a child who is struggling with a stealing problem in an atmosphere pervaded with stealing is only to increase his problem. To place him in an institution without the kinds of services he particularly needs creates a destructive experience for him.

Treatment begins when the child enters the institution. Only when the personnel has knowledge of the child's background and attitudes can it be geared from the beginning to help him. The importance of social histories was brought home to us at the Albany

Children's Home recently when we accepted a little girl for a 2-day stay for simple custodial care prior to her placement in a foster-family home, already arranged for her by another agency. This child wanted desperately to talk about what was happening to her. She had questions about the home she was going to and why she was going there. She needed help at that moment and turned to us for it, but we were unable to give it to her because we knew nothing about her or the plan for her.

An institution is not omniscient. Even given the best of social histories, it will make mistakes in its intake. In some cases it will agree to take a child on trial because it cannot be sure of whether it can help. But its errors will be considerably lessened if it can plan for the child with the referring agency on the basis of shared ideas and information.

Preparing the Child

One of the most difficult and traumatic experiences a child can go through is having his familiar life disrupted and being moved into a new environment. In being taken from his own home no matter what its quality, a child is going from the known to the unknown. He is leaving the blood relatives who have given him whatever feeling of safety he may have had in life. However, if he is going into a foster-family home he is at least entering a setting which has a familiar form. On the other hand, when he moves into an institution he faces a pattern of living entirely different from any he has ever known. Adding to his fears, moreover, are often the distorted ideas he may have about what an institution is like. Being sent to an institution may have been a threat held over him in the past with bizarre and ominous stories.

Our initial impressions of any new situation greatly affect our ability to adjust to it. The child who comes to the institution frightened about what it will mean or do to him, or the child who comes with bitter feelings about being taken from his family, will retain some of these feelings throughout his stay no matter how hard the staff tries to help him.

For these reasons a child about to be placed in an institution needs adequate preparation for the move. This means careful explanation, repeated several times, perhaps, with a chance to ask questions about the institution and to talk out some of his feelings about going. If possible, he should be taken for a visit to the institution before placement to see the physical surroundings and to meet some of the people with whom he will be living. If the place looks familiar to the child when he is admitted and if he sees a few people whom he has previously met, the experience becomes much less frightening and confusing.

The child should understand as clearly as possible why he is going to the institution and why placement is necessary. Often, we institutional and placement workers are not completely frank with children because it is difficult to face reality with them. We hide behind false reasons or half-truths for our explanations. We tell a child he must live away from home because his family does not have a proper house, when the real reason is that even in the best of houses his parents could not or would not give him proper care. A child must understand at least some of the reality behind his placement if he is to use the experience on a realistic and helpful basis.

If the child's parents take part in the placement plan, this helps. When they can accept the reality of the placement need, assist in making the plans, and back the placement worker, the experience is apt to be less traumatic for the child. He can then feel his parents are making the plan for his welfare, that they are continuing to care for him, at least to some extent, even though not in the same way he is used to. This helps to mitigate his feeling of being deserted or snatched away by strangers.

The better the child is prepared for placement the better he will be able to accept institutional living and gain from it. This does not mean that he will necessarily be happy about it. Actually, an experienced institutional worker is apt to worry more about the child who apparently accepts placement easily than the child who is able to express feelings about it.

A year ago we received at Albany a brother and sister whose parents had both died so recently that the referring agency decided they were not yet able to take on new parent-figures, but needed the more impersonal relationships available in a group setting. They had been carefully prepared for the institution by a good worker and had paid it a preadmission visit. At that time the girl expressed strong opposition to the whole plan, cried and said she would not live in such a setup. But at the height of her outbursts she would interject such questions as "Where will I go to school?" showing that while she did not like the idea, she was accepting the realities of the situation. Her brother, on the other hand, expressed complete acceptance of the plan. He talked as though everything about the place were wonderful and he could not wait to start living there.

Once these children had entered the institution, the girl continued expressing opposition to the placement. According to her nothing was really right, the food was terrible, none of the plans made for her were good. Nevertheless we watched her obviously enjoying many experiences. She continued her vocal opposition for about 6 weeks, then began to accept the home and within a few more weeks was well adjusted and was beginning to use the setting to help develop herself as a person.

The boy who had seemed so happy about the prospects of entering the institution began to develop severe stomach aches and other physical symptoms a few weeks after admission. He had troubles with other boys, his schoolwork was inadequate, and in general he showed a very poor adjustment. Because he kept all his feelings bottled up inside himself it took him much longer really to accept the situation than it did his sister who learned to handle her feelings more quickly because she was able to get them out in the open.

Such seeming paradoxes in attitudes and behavior are common among children away from their own homes. They indicate that persons who work with these children must not be afraid of allowing them to express their feelings, but on the contrary must help them to talk these out.

Continuity and Planning

It is an old saying that discharge from an institution starts with placement. If the institutional stay is part of a treatment plan rather than custodial care, then the institution must know what it is expected to achieve and have some idea of what the next step for the child will be. When the placement is made the worker from the referring agency and the worker from the institution should set some tentative goals together in regard to the child's length of stay in the institution and what might happen to him afterwards. Because they involve people and not laboratory specimens, these goals will have to be tentative, subject to change as time goes on. Even so, the planning will help everyone concerned to see his job in a broad scope and to focus efforts on the child's needs. As the child develops he will necessarily be the subject of many more conferences between the institutional and referring agency personnel.

Sometimes placement workers feel that when they have moved a child to a group residence, they can drop out of the picture until the time comes for the child's removal, especially if the institution has caseworkers on its staff. Actually, the institutional worker can never take the place of the caseworker who carried the child through the placement experience and who the child knows will be making future plans for him. The worker who has made the placement holds great importance for the child as a cord tying together past, present, and future, especially if she is continuing to work with the child's family. If the institution is not in the child's home community, the placement worker also represents the link between that community and the child.

The institutional caseworker must have the help of the worker from the referring agency in keeping informed of what is going on within the child's family if he is to work successfully with the child. The child still remains a part of his family though he is physically separated from it and the happenings in the family are of great importance to him. Every once in a while a child in an institution begins to act in a way which cannot be accounted for in the light of his usual behavior or what has been happening to him in the group. Then the staff learns of some change in his family or in the family's attitude and begins to understand what the child is reacting to. If the institutional caseworker knows of family developments early, through the placement worker, the child can be helped to handle his reactions.

Continuous contact between the institutional and placement-agency personnel works both ways. Children change, sometimes rapidly, and unless close working arrangements exist between the agencies, the community worker is not kept aware of these changes. Moreover if this worker's aim is toward return of the child to his own home, she must be able to let his family know what is happening to him in the institution.

Most institutions have to depend on the community agency for casework service with the child's family. Certainly, if there is a possibility that the child will return to his own parents, continued casework contacts are essential for helping them to change the situation which required the child's removal, to recognize changes in the child, and to prepare for his return. In most instances both the child and the family need expert help in changing if return home is to prove profitable for the child.

Even a child whose parents are clearly not going to offer him enough of a home to make his return home a possibility is going to remain a part of the family emotionally, and his relationship to its members will still be a very potent factor in his development. In rare instances it may be necessary to separate the child from his parents as completely and as permanently as possible. Usually, however, even when it is felt that contacts with his parents may be damaging for a child, it must be recognized that contacts will continue. They may come only at Christmas time when maternal and paternal feelings become strong and sentimental; they may be separated by several years or not occur at all until the child is old enough to initiate them himself. But because contacts will occur, rarely or frequently, at some time in the future, continued work with the family while the child is in the institution is of great importance.

If the parents want to, they can sabotage with a few words all that an institution may be able to accomplish in months of work. When this happens the casework effort with the family has to be aimed at helping the parents to accept continued placement for their child and to help the child accept it. Sometimes the caseworker's role may be as a sort of whipping boy on whom the parents can vent their feelings instead of on the child—not a pleasant role, but one which must necessarily be assumed for the child's welfare.

At Time of Removal

If the institution is a treatment process, then a times comes when it has done as much as it can for the child and has little or nothing left to offer him through continued care. The child has reached a point of development where he is ready for another step—a move either to his own home, a foster home, or to some other living arrangement. Usually, if a child remains in the institution beyond this time, he becomes thwarted in his efforts to grow and, since children rarely stand still for any real length of time, he begins to slip backwards. Because of this danger the institutional and community caseworkers must be alert in recognizing the point when the child is ready for a new plan. Too frequently children remain in an institution beyond this point either because it is not recognized or another plan cannot be made at the time.

Even though a child is quite ready for another move, as far as what the institution can do for him is concerned, a precipitant move is as dangerous as one too long delayed. Most children, if not all, find it as difficult to move out of the institution as they did to move in. If they are going to a foster home, they are again facing the unknown and leaving behind the safety of the known. Even when they are returning to their own home, in a sense they face a new experience, for they have changed since they have been away. Therefore they need careful and skilled help to prepare them for leaving. They need the same chance to think about the move and to talk out some of their doubts and feelings that they did when they were admitted.

Frequently when we start preparing a child for the next move, he is able for the first time to talk over things that have bothered him all during his stay. The fact that change is impending frees him to face these things and work them out.

In preparing a child for leaving, the institution and the community workers should again work together, with especially careful arrangements and timing. If the child is returning home, it is a time for intensive work with the family. His parents, too, may have fears and questions along with their eagerness for the child's return. Very likely they have failed the child before or he would not have been removed. He has had new experiences and may have changed so that they cannot be sure they really know him or that he will accept them. The more chance they have to work these feelings out with a caseworker prior to and immediately following the child's return, the better the chance of success for the family and the child.

There are no easy answers for the child who has gone through years of disturbed family life and who has been taken away from his own parents and placed with strangers. No one agency has a monopoly of the tools needed to help these children grow into healthy adulthood. Usually it takes the combined and best efforts of several. The institution needs to strive constantly to develop the best possible services. The community and the child-placing agency have to recognize that it is necessary for institutions to have highly skilled staffs and programs and that such services cost money.

To do their jobs adequately both the child-placing agency and the institution must develop the strongest services they can and must be able to combine their efforts to help the child. This calls for easy communication between the two, a freedom to express opinions and ideas, and a willingness to listen to each other on a professional level. The only real measure of services must be: "Are these services what I would want for my own child, if through some misfortune he were in the situation of the child we are working with?"

Unless they are that good, they are not good enough.

PROJECTS AND PROGRESS

Social Statistics

According to recent reports of the Bureau of the Census:

In 1955, of the 55,100,000 children under 18 in the United States, 47,700,000 were living with both parents, 5,800,000 with one parent, and 1,600,000 with neither. Of those living with one parent, 1,500,000 were in *families broken* by death; 1,100,000 by divorce; 1,500,000 by estrangement or legal separation; 1,700,000 were in families broken by the father's absence with the Armed Forces or through other circumstances. Only 600,000 children were living with their fathers only; 5,200,000 with their mothers only.

More than 1 in 4 mothers with children under 18 were in the labor force (employed or seeking employment) in 1955.

In April 1955 more than 31 million persons 1 year old and over had *moved* since April 1954—11 percent more than had moved during the previous year. Of those who moved, about 21 million still lived in the same county, about 5½ million had moved to a different county in the same State, and nearly 5 million had moved to a different State.

Families with children did more moving than did those without. One-fourth of the families in this country made up of husband, wife, and one or more children of their own moved during the year, but only one-fifth of the families including only husband and wife.

In 1954 *large families* continued to carry a disproportionate share of the responsibility for rearing the Nation's children. Families with 3 or more children under 18 constituted only 18 percent of all families in that year, but they included 54 percent of the children. Only 8 percent of the total families had 4 or more children, but 30 percent of the country's children belonged to these families.

The *median family income* for the Nation as a whole was $4,173, slightly lower than in 1953, when it was $4,233. For large families, however, it was still lower: $3,949 for families with 4 children; $3,155 for families with 5 children; $3,252 for families with 6 or more children. Of the Nation's 42 million families, 8 million, or one-fifth, had incomes under $2,000 in 1954.

Per capita income in the States ranged from over $2,300 in Nevada, Delaware, and Connecticut to less than $1,000 in Mississippi and Arkansas.

Boys had only a slight edge over girls in the *sex distribution* of unmarried children living with one or both parents in 1954–55. The ratio was 103 boys to 100 girls. Based on sample surveys, this information was the first of its type gathered by the Bureau of the Census. Forty-one percent of the families surveyed had both boys and girls; 30 percent had all boys; 29 percent had all girls.

The Office of the Commissioner of Social Security reports:

In December 1955 about two-thirds of the 1,800,000 children under 18 in the United States whose fathers had died but whose mothers were living were receiving benefits under one or more of the social-insurance and related programs: Old-age and survivors' insurance, railroad workers' or public employees' retirement systems, or veterans' compensation or pension programs. Almost three-fifths of all the paternal orphans were receiving OASI benefits. Ten percent of them were receiving allowances under the aid to dependent children program, about two-fifths of these in supplementation of OASI benefits that were considered inadequate for their needs. The percentage of the children on the ADC rolls who were in need because of the father's death has been declining steadily; in late 1953 it was 15½ percent; in mid-1948 it was 23 percent.

Vital Statistics

Recent figures from the National Office of Vital Statistics show that:

More than 4 million *babies were born* in the United States in 1955. The provisional birth rate was 24.9 live births per 1,000 population—a rate close to the highest reached in the last 30 years, 26.6 per 1,000 in 1947.

For the first 4 months of 1956 the provisional *infant mortality* rate was 26.6 deaths of infants under 1 year of age per 1,000 live births, the lowest such rate ever recorded.

Reported fetal deaths numbered 70,109 in 1954, and deaths in the first month of life, 76,724. These amounted to a *perinatal mortality* of 35.9 deaths per 1,000 total births. Of the infants that died in their first month of life, 59 percent had been prematurely born as had 43 percent of the 106,791 who died in their first year.

About 10 percent more babies were *born out of wedlock* during 1954 than during 1953. The total estimated for 1954 was 176,600: of these, 62,700 were white, 113,900 nonwhite. Forty percent of the unmarried mothers were under 19 years of age. Between 1940 and 1954 the proportion of unmarried women bearing children rose from 7 per 1,000 to 18 per 1,000.

Maternal mortality continued to decline in 1955; the provisional rate—4.8 maternal deaths per 10,000 live births—was the lowest ever recorded. The rate has gone down steadily since 1929, when it was 69.5 per 10,000. However, 1,950 mothers are estimated to have died from causes connected with childbearing in 1955.

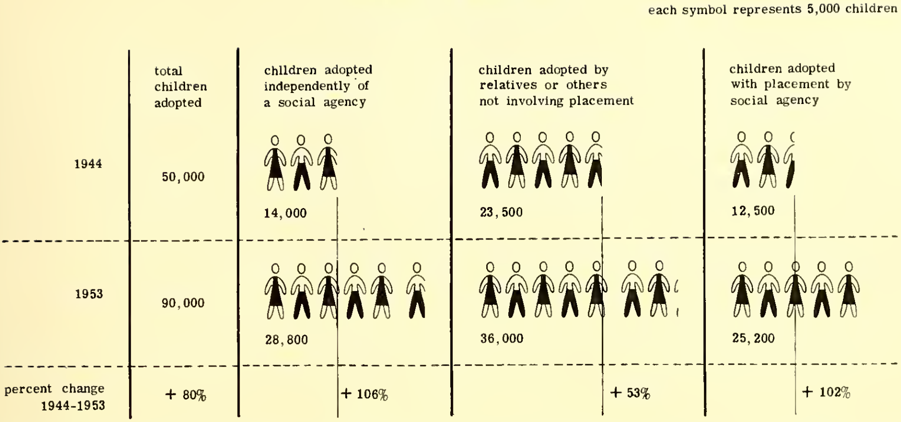
Among the States, Vermont had the lowest rate—for the 2 years 1953 and 1954 combined—1.6 maternal deaths per 10,000 live births; eight States in the South and Southwest had rates five or more times greater than Vermont's.

The leading cause of maternal deaths in 1954 was toxemia; next was hemorrhage.

In 1954, as in many previous years, accidents were the most important *cause of children's deaths*, accounting for 16,189—or 38.6 percent—of the deaths in the age group 1–19 years. The accident mortality rate was highest among children 15–19 years old—49.9 deaths per 100,000 children; and next highest—33.6 per 100,000—among children 1–4. Among children 5–14 deaths from accidents were less frequent—20.3 per 100,000—but this rate was more than three times as high as the death rate for any other cause in this group.

Among children 5 to 19 years old who died of disease in 1954, cancer was the leading cause of death, as it was in a number of previous years, causing 6.7 deaths per 100,000 children in the age group 5–14 and 7.6 deaths per 100,000 children 15–19 years. Next in impor-

GROWTH OF ADOPTION



As the chart shows, the upward trend in adoptions has involved primarily adoptions by nonrelatives; and these have divided rather evenly between social-agency and "independent" adoptions. Later figures show agency adoptions gaining slowly. But why are agency services bypassed by so many mothers who wish their babies placed for adoption? Is it need for help with expenses? Desire for secrecy? Misconceptions about agency services and resistance to them? How do mothers who seek social-agency services differ from those who do not? These questions and others are being explored by the Children's Bureau and the Elizabeth McCormick Memorial Fund. Interviews with unmarried mothers are under way as a background to planning a large study. The explorative phase of the investigation is underwritten by the Field Foundation.

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tance among fatal diseases were diseases of the heart and acute rheumatic fever among children 15–19—5.1 per 100,000; congenital malformations in the 5–14 group—2.7 per 100,000; and influenza and pneumonia in the 1–4 group—16.1 per 100,000.

Recent Congressional Action

Among the laws enacted by the 84th Congress before adjourning July 27, 1956, were a number that affected children. These included measures concerning child-welfare services, old-age and survivors insurance, public assistance, medical care for servicemen's dependents, and nutrition.

Children's Bureau Appropriations. Congress appropriated $39,361,000 for grants to the States for the fiscal year 1957 under the three grant programs administered by the Children's Bureau—maternal and child-health services, crippled children's services, and child-welfare services. (Public Law 635, approved June 29, 1956.) This is $5,204,400 more than the appropriation for 1955–56. The law earmarks $1 million of this money for special projects for mentally retarded children, to come out of the grants for maternal and child-health services.

The total appropriation for maternal and child-health services is $16 million as compared to $11,927,700 in 1955–56. The new appropriation comes within $500,000 of the maximum amount authorized for these grants under the Social Security Act, as amended.

For the second year in succession the appropriation for grants for crippled children's services is the same as the amount authorized in the act—$15 million.

The appropriation for child-welfare services ($8,361,000) was 14 percent greater than the 1955–56 appropriation of $7,228,900. However, the new appropriation is still only 84 percent of the amount authorized—$10 million.

Funds appropriated for Children's Bureau salaries and expenses came to $1,822,000. Last year the total appropriation came to $1,740,000. Much of this year's increase will be used for employing 12 workers in the field of mental retardation in addition to the one already on the staff.

Social Security Amendments of 1956. For the fiscal year beginning July 1, 1957, and thereafter the highest amount that Congress may appropriate for grants to States for child-welfare services in a year will be raised to $12,000,000. At present it is $10,000,000.

Numerous important changes were made in the present old-age and survivors insurance provisions of the Social Security Act. Among these are provisions to extend coverage to about 850,000 additional persons. This will mean that more children will have the protection of insurance benefits under this program.

Another important change was the provision of insurance benefits for children aged 18 and over who were totally disabled before age 18. If the disabled child was entitled to benefits before age 18, his benefits will be continued so long as he is totally disabled. Otherwise his benefits begin when the parent on whom he is dependent becomes entitled to old-age benefits or dies, regardless of the child's age at that time. It is estimated that about 20,000 children will be added to the benefit rolls in the first year; annually, about 2,500 disabled children will be either currently attaining age 18 and continued on the benefit rolls or will be added to the rolls at age 18 or over when the insured parent dies or becomes entitled to old-age insurance benefits.

Several significant changes were made in the public-assistance provisions of the Social Security Act. Among these were provisions that will have the effect of increasing the public-assistance grants to children receiving aid to dependent children. Another change was the deletion of the requirement of school attendance for children between the ages of 16 and 18. The definition of relatives with whom children may live and be eligible for payments under the ADC program was broadened to include first cousins, nephews, and nieces.

Nutrition. An increase of more than 20 percent in funds for the Department of Agriculture's school lunch program was voted by Congress for the 1956–57 fiscal year, bringing the sum up to $100,000,000. (Public Law 554, approved June 4, 1956.) Congress also, for the second time this session, broadened eligibility for the Department's special milk program for children. Henceforth, in order to serve milk under the special program, nonprofit nursery schools, summer camps, and similar institutions need not be solely for economically underprivileged children. (Public Law 752, approved July 20, 1956.)

Servicemen's dependents. Medical care and hospitalization for dependent children of servicemen in nonmilitary medical facilities can be paid for by the Defense Department, under Public Law 569 (approved June 7, 1956), effective December 7, 1956. This law enables the Defense Department to contract for civilian medical services for these children under insurance and similar plans. Included in dependent children are adopted children and stepchildren who are unmarried, legitimately born, and under 21. Certain children over 21 may also have their medical care bills paid.

Federal grants, under Public Law 634, approved June 29, 1956, provide "opportunities for education to children whose education would otherwise be impeded or interrupted by reason of the death of a parent from a disease or injury incurred or aggravated in the Armed Forces . . . and to aid such children in attaining the educational status which they might normally have aspired to and obtained but for the death of such parent." Children between 18 and 23 of a deceased parent who served in World War I or II or in the Korean conflict may apply for the scholarships under this program. Regular high-school training is not covered by this law. For children with physical or mental disabilities that would hamper regular education the law provides for special training covering such fields as speech correction, braille reading and writing, and one-hand typewriting.

Juvenile Delinquency. A bill (S. 4267) to enable the Federal Government to give financial help to the States in combating juvenile delinquency was passed by the Senate on July 27, 1956; no action on it was taken by the House of Representatives.

Under the proposed act, grants of Federal funds would have helped States in strengthening and expanding State and local delinquency programs and stimulating new ones; in training personnel in the juvenile-delinquency field; in expanding research; and in conducting demonstrations and special projects in this field. The Secretary of Health, Education, and Welfare would have been authorized to make such studies demonstrations, and reports as would improve programs for dealing with juvenile delinquency; to give technical assistance to States in carrying out delinquency programs; and to provide short-term technical courses to train personnel. A Federal Advisory Council on Juvenile Delinquency, made up of people eminent in fields related to juvenile delinquency, would have been established to advise the Secretary of Health, Education, and Welfare on matters concerning delinquency programs.

Adoption. The Senate on July 26, 1956, passed a bill (S. 3021) planned to protect children, natural parents, and adoptive parents involved in interstate placing of children for permanent free care or adoption. The House took no action on the bill.

An extended investigation in 1955 and 1956 by the Senate Judiciary Subcommittee to Investigate Juvenile Delinquency established that there exists a continuing and sustained commercial traffic between the States in which children are being placed for adoption on a commercialized basis by unscrupulous individuals. There is at present no Federal law making interstate baby selling a crime.

The proposed legislation would have made it a Federal criminal offense for anyone to engage in interstate commercial traffic of placing children for adoption. It would also have required in all cases where a child is placed for permanent care or adoption across State lines a study of the prospective foster or adoptive home before the placement was made.

Youth Fitness

As a step toward improving youth fitness in this country, the President of the United States recently established two groups—a Cabinet members' council and a citizens advisory committee. He took this action upon the recommendation of the President's Conference on Fitness of American Youth, attended by experts in the fields of health, physical education, recreation, sports, and communications media, and by heads of Government agencies. The Conference met at Annapolis, Md., for 2 days last June under the chairmanship of the Vice President.

The members of the Cabinet group, which is called the President's Council on Youth Fitness, are: the Vice President, chairman; the Attorney General; and the Secretaries of the Interior; of Agriculture; of Labor; and of Health, Education, and Welfare. The Council, the President explained, will coordinate, stimulate, and improve the work of some 35 Federal agencies with respect to youth fitness. It will promote the efficacy of present programs and the launching of additional ones. Staff members of various Government departments will assist the Council in this work.

Nongovernmental persons representing various interests will make up the President's Citizens Advisory Committee on the Fitness of American Youth. The Committee will, in the President's words, "explore the facts on young people's mental, emotional, and spiritual strength and alert the country on ways of developing a happier and more totally fit youth."

The Annapolis Conference stressed the responsibilities of the school, the family, and the community for improving the fitness of youth and agreed that present programs are inadequate. In group discussions the participants voiced differences in viewpoint with regard to the validity of certain tests of fitness, the place of competitive sports in schools, and the role of the Federal Government in a nationwide fitness program.

Child Welfare

As part of a broad plan to extend welfare services to children and young people, the Pennsylvania State Department of Welfare recently reorganized its Bureau of Children's Services, creating a new Youth Rehabilitation Division and merging two former divisions into a new Child Care Division.

The Youth Rehabilitation Division was established to carry out the provisions of new legislation requiring the department to develop a coordinated guidance and assistance program for preventing and treating juvenile delinquency. Its responsibilities include: helping public and voluntary agencies to improve their programs and train personnel for treating delinquents; helping juvenile courts and other agencies to study delinquents and other children with mental and behavior problems and to recommend appropriate treatment. The division will establish residential centers for study of children committed to its custody by the courts. It will continue to operate the Morganza State training school for delinquents and to supervise all other correctional institutions for children.

The new Child Care Division created by the merger of the former Division of Rural Child Welfare and Division of Field Services gives consultation to local public and private agencies on foster boarding care, institutional care, protective and counseling services, day care, and adoption. It also assists communities in developing community programs and resources for social services to children, and has responsibility for supervision or consultation to public and private child-caring organizations, including day-care centers and maternity homes.

Recent legislation also provides for appointment of a commissioner of mental health in the department, giving him responsibility for developing a broader program of services to mentally retarded persons both inside and outside of institutions. Other legislation requires each school district to take a complete census of all handicapped children and provide for their education. The district must also provide transportation for every handicapped child who would otherwise not be able to attend classes.

Here and There

As a step toward saving the lives of children who climb into refrigerators, the National Bureau of Standards, U. S. Department of Commerce, with consultation from the Children's Bureau, Department of Health, Education, and Welfare, is carrying on a 3-month study of children's reactions to various types of mechanisms for opening refrigerator doors from the inside. The tests, which are financed by the National Electrical Manufacturers' Association, are one phase of an extensive effort by the association to develop safety devices for refrigerators and other airtight enclosures, which was begun at the request of a congressional committee.

. . .

The National Conference on Social Welfare is the new name of the former National Conference of Social Work. The name was changed July 1, 1956, by a vote of the members.

. . .

This country's first endowed professorship of child psychiatry will soon be established at the Washington University School of Medicine, in St. Louis, with a $400,000 gift recently granted by the Ittleson Family Foundation. The new program will include research, training, and community leadership in child psychiatry, pediatrics, psychology, and other related fields. The university expects to obtain additional support for the program from the St. Louis community and other appropriate sources.

. . .

An advisory center on careers in social work opened recently in New York City, sponsored by four schools of social work and a number of welfare and health associations, with funds from the Ittleson Family Foundation.

Erratum. The figure given in CHILDREN for July–August, page 154, column 2, as the amount granted by the National Institute of Mental Health to the American Association on Mental Deficiency for its study of technical planning in the field of mental retardation should have been $232,000. CHILDREN regrets the error.

Guides and Reports

THE EVALUATION AND TREATMENT OF THE MENTALLY RETARDED CHILD IN CLINICS; papers given at a professional training institute, March 14–17, 1956, New York, N. Y., cosponsored by New York Medical College and the National Association for Retarded Children, Inc. The Association, 99 University Place, New York. 1956. 132 pp. $1.25; 10 or more copies, $1 per copy.

Brings together contributions by pediatricians, psychiatrists, psychologists, social workers, and others, in a training institute planned to broaden and extend professional understanding of the best team methods of providing clinical services to the mentally retarded.

CHILDREN HERE AND NOW, No. 3; notes from 69 Bank Street. Bank Street College of Education, New York. 1955. 39 pp. 65 cents.

Introduced by Lucy Sprague Mitchell, author of "The Here and Now Story Book," this booklet offers a dozen items, such as a progress report of a study of the impact of stories on children; a word-for-word record of 20 minutes' "play in slow motion" among four 3-year-olds in nursery school; stories and poems written by children 6 to 10; and a teacher's description of work with preschool deaf children.

THE FOOD PROGRAM IN CHILDREN'S INSTITUTIONS; a handbook. Illinois Department of Public Welfare, Child Welfare Services, Springfield. 1955. 84 pp. Single copies from the Illinois Department of Public Welfare without charge.

Children's eating habits, needed foods, meal planning, food purchasing and storage, food preparation, equipment and layout, factors affecting food costs, sanitation, and board and staff cooperation are discussed in this handbook. Appendices contain recommended daily dietary allowances, sample weekly menus, and low- and moderate-cost food plans for various age and activity groups.

BOOK NOTES

MENTAL HEALTH PLANNING FOR SOCIAL ACTION. George S. Stevenson. McGraw-Hill Book Co., Blakiston Division, New York. 1956. 358 pp. $6.50.

Addressed to "all who work and plan for mental health," this book by the national and international consultant to the National Association for Mental Health aims to present the broad field of mental health in perspective, showing the interrelationship and independence of its parts. It sets forth six criteria for weighing, ahead of time, the relative importance of a mental-health undertaking, and suggests 12 steps to be taken in planning a program.

Noting three objectives of mental-health programs—the restoration of mental health, its preservation, and its improvement—the author devotes major attention to describing the efforts of various types of agencies that work toward one or more of these goals.

In a section on home and family, he points to the psychological dangers of a widespread abandonment of breast feeding. He also discusses the values of marriage counseling, parent-education, and nursery-school study of child development in the promotion of mental health.

The book includes a list of motion pictures that illustrate many of the author's concepts.

HOW TO ADOPT A CHILD. Ernest and Frances Cady. Whiteside, Inc., and William Morrow & Co., New York. 1956. 189 pp. $3.

Written by a husband and wife who have three adopted daughters and a son of their own, this book advises would-be adoptive parents to apply to a licensed child-placing agency for a child, and warns against using the black or gray market; explains what applicants may expect of child-placing agencies and what the agencies may expect of them; and points out some of the difficulties that agencies face. It discusses adoption of older children, handicapped children, children from overseas, and Negro children. It also gives advice on how and when adoptive parents should tell the child about the past.

The book presents information on laws concerning inheritance by an adopted child, birth certificates, revocability of adoption decrees, decrees granted outside the adoptive parents' home State, and citizenship of an adopted child born outside the United States. It also lists the addresses of State welfare agencies and licensed child-placing agencies according to State.

CHILD DEVELOPMENT AND PERSONALITY. Paul Henry Mussen and John Janeway Conger. Harper & Bros., New York. 1956. 569 pp. $6.

In this textbook the authors trace the various aspects of child growth and development—physical, intellectual, social, and emotional—through various periods from prenatal life to adolescence, and points out the interdependence of these factors in influencing the development of personality.

CASE STUDIES IN CHILDHOOD EMOTIONAL DISABILITIES. Vol. 2. Edited by George E. Gardner. American Orthopsychiatric Association, New York. 1956. 368 pp. $5.

Presented by workers in three fields—child psychiatry, cilnical psychology, and psychiatric social work—the case studies reported in this volume, like those in the preceding one issued 3 years ago, demonstrate a varidisciplinary approach to the diagnosis and treatment of children with emotional difficulties.

THE TEACHER AND THE CHILD; personal interaction in the classroom. Clark E. Moustakas. Foreword by Dorothy Lee. McGraw-Hill Book Co., New York. 1956. 265 pp. $4.50.

How efforts to participate more deeply in the emotional experiences of a child can help the teacher to establish a good personal relationship with him is suggested in this book, written by a staff member of Merrill-Palmer School. On the theory that a child's emotional development in a normal atmosphere parallels that of a child's growth in play therapy, the author offers excerpts from a recorded account of such therapy. He also presents similar illustrations of teacher-child personal relations at various stages of school life—kindergarten, early and late elementary grades, and high school—based largely on tape recordings by 92 teachers in four different school systems. Of these teachers, 67 evaluated their efforts toward better relations with children as worthwhile, and 9 as unsuccessful; 16 were uncertain about the results. The book reports examples of all three types.

THE HOME-MENDERS; the prevention of unhappiness in children. Basil Henriques. George G. Harrap & Co., London. 1955. 192 pp. (U.S. distributor, John de Graff, Inc., 31 East 10th Street, New York 3, N. Y.) $2.50.

From his experience of 30 years as a magistrate in a London juvenile court, and of more than 40 years helping to run boys' clubs, the author of this book offers suggestions on what can be done through preventive family casework to keep children from becoming criminals. Observing that the source of children's unhappiness usually lies in the home, he discusses the share of each parent in keeping the family intact and urges that education workers and others in contact with children watch for signs of family trouble so that steps can be taken to prevent break-up. Describing the British system of helping deprived children, he suggests some changes which could be brought about without new legislation.

CHILDREN AND OTHER PEOPLE; achieving maturity through learning. Robert S. Stewart and Arthur D. Workman. Foreword by Erich Lindemann. Dryden Press, New York. 1956. 276 pp. $2.25.

Planned to help teachers and parents do a better job for children, this book attempts to make clear how a child's personality develops, how he learns, and how he reacts to adults. The authors stress personality factors common to adults and children, and urge adults to try to recognize and relieve their own emotional tensions concerning children. The book includes a list of recommended readings, with critical annotations.

FILMS ON CHILD LIFE

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

THE BOY WITH A KNIFE. 18 minutes, sound, black and white, purchase or loan.

Demonstrates how a professional social worker brought a teen-age gang into a constructive program of activity.

Audience: PTA's, church groups; also social workers and law-enforcement workers.

Produced by: Dudley Pictures Corp., 1051 South Westmoreland Avenue, Los Angeles 6, Calif.

Distributed by: Sale—Los Angeles Community Services; loan—local community service agency.

HE WHO DARES TO TEACH. 18 minutes, sound, color, purchase.

Shows the parents of a 4-year-old girl learning to understand her puzzling behavior through joining a parent-education program—a nursery school in which parents participate.

Audience: Parents and teachers of young children.

Produced by: Hal Moulin & Associates, with the Bureau of Adult Education, California State Department of Education.

Distributed by: Hal Moulin & Associates, 4420 Melrose Avenue, Los Angeles 29, Calif.

HEROINE OF THE WEEK. 6 minutes, sound, black and white or color, purchase.

Shows how a babysitter saves lives from a threatened fire through her school safety training and her employers' precaution in placing appropriate telephone numbers near the telephone.

Audience: Lay and professional groups, especially students.

Produced by: Washington Video Productions for the National Board of Fire Underwriters.

Distributed by: Bureau of Communication Research, Inc., National Board of Fire Underwriters Film Library. East of Rocky Mountains, 13 East 37th Street, New York 16, N. Y.; west—465 California Street, San Francisco 4, Calif.

KID GANGS. 26 minutes, sound, black and white, rent or long-term lease.

Depicts juvenile gangs in action. Explains the role of social agencies and of the police in combating the gang problem. Discusses some of the factors in gang activities and delinquency. Film is an episode from the weekly television program, "Confidential File."

Audience: Training and inservice courses for police and other law-enforcement workers.

Produced by: Guild Films, 460 Park Avenue, New York 22, N. Y.

Distributed by: Same.

FAMILY LIFE OF THE NAVAHO INDIANS. 31 minutes, silent, black and white, purchase or loan.

Presents episodes in infant care, homemaking, economic activity, and recreation among the Navahos. One of the Series of Studies of Integrated Development—The Interaction Between Child and Environment.

Audience: Students of social sciences.

Produced by: Margaret E. Fries, Clyde Kluckhohn, and Paul J. Woolf.

Distributed by: New York University Film Library, 26 Washington Place, New York 13, N. Y.

TOO YOUNG TO SAY. 13½ minutes, sound, color, loan.

Demonstrates the difficult and costly procedures involved in testing the hearing of a small child. Shows how an audiometric test is made into a game for a little boy too young to cooperate in the examination.

Audience: Nursery-school teachers, workers in child-care centers, public-health nurses, other professional workers with children, and parents.

Produced by: University of Southern California Cinema Department.

Distributed by: Beltone Hearing Aid Co., 2900 West 36th Street, Chicago 32, Ill.

BABIES LIKE TO EAT. 10 minutes, sound, color, purchase.

Illustrates the eating behavior of twin boys from the time they were about 5 or 6 months old until they were well over 2 years. Discusses such questions as when to start cup feeding and how to give solid foods.

Audience: Parents and students.

Produced by: Hard Castle Films for the Dairy Council of St. Louis.

Distributed by: Social Science Films, 4030 Chouteau Avenue, St. Louis, Mo.

THE WAY OF THE NAVAJO. 45 minutes, sound, black and white, purchase.

Pictures American Indian life on a reservation and away from it, and suggests some of the emotional difficulties of adjusting to life off the reservation as well as some of the differences in handling sick children.

Audience: Citizens' groups.

Produced by: Columbia Broadcasting Co.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

THURSDAY'S CHILDREN. 22 minutes, sound, black and white, purchase or rent.

Shows children 4, 5, and 6 years old being taught to speak at the Royal School for the Deaf, Margate, England.

Audience: Workers with children who have handicaps (not only those with impaired hearing), parents, general public.

Produced by: World Wide Pictures, Ltd.—Morse Films.

Distributed by: British Information Services, 30 Rockefeller Plaza, New York 20, N. Y.

IN TIME OF TROUBLE. 14 minutes, sound, black and white, purchase.

Suggests that some unhappy homes can be made happier if the mother lets the father take a greater share in the family activities.

Audience: General public, especially young married couples.

Produced by: Affiliated Films.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

IN THE JOURNALS

Developing Responsibility

As part of a symposium on developing responsibility in children, published in *Child Study*, summer 1956, Nathan E. Cohen, associate dean of the New York School of Social Work, discusses the question of how children can be helped to develop creative independence and at the same time achieve an understanding and respect for the interdependence of people in a democratic society. This, he maintains, requires not only helping the child to learn to make choices by freeing him from authority, but also "taking into account those factors out of which the choices must be made"—our social institutions and the values and conflicts they include.

Children, the author suggests, should be helped to an understanding not only of the facts about our social institutions, but also of the reasons for their existence and for the gaps in democratic achievement.

Retrolental Fibroplasia

After an 8-year steady rise in New York State the incidence of blindness due to retrolental fibroplasia took a sudden and continued drop in 1954, as hospitals reduced the amount of oxygen administered to premature babies, according to the May 1956 issue of *New York State Journal of Medicine*. Data on this type of blindness before and after studies had established the relation between the development of retrolental fibroplasia and exposure of premature infants to concentrations of oxygen greater than 40 percent are presented by Alfred Yankauer, M. D., director of the Bureau of Maternal and Child Health Services, New York State Department of Health; Harold Jacobziner, M. D., assistant commissioner of health, New York City, in charge of maternal and child-health services; and David M. Schneider, Ph.D., director of the Bureau of Research and Statistics, New York State Department of Social Welfare.

The figures show that the number of children classified as blind increased from 4 in 1946 to 52 in 1953 and declined to 3 in 1955—a reduction between 1953 and 1955 of 94 percent. The number classified as blind during the year after their birth year, when most cases are reported, rose from 3 in 1946 to 92 in 1953 and declined to 27 in 1955. Yet in 1954 and 1955 the number of premature births in the State rose slightly.

The authors describe efforts of the New York City and State health departments to help hospitals modify their practices in oxygen therapy for the newborn. They also describe a followup study of 69 children reported in 1955 as blinded by retrolental fibroplasia, more than half of them born before 1954. This showed that all but one had been born prematurely and had received oxygen in high concentrations and for long periods.

Research on Delinquency

Sound planning for a State welfare agency's delinquency program must be based on information including far more than a case count, says W. P. Lentz in the July 1956 issue of *Public Welfare*. The crucial issues, says he, are the amount and kinds of services offered to each juvenile delinquent, not only by the juvenile courts but by all agencies in the field. He maintains that as a step toward finding out where services are inadequate to meet a community's needs, the State agency must know the answers to such questions as: Was probation granted, and if so, how early? Were psychiatric facilities necessary? Were casework services offered, and if so, who provided them?

A public agency's research, the author maintains, must pursue a two-sided attack: study of the individual, his characteristics and problems; consideration of the community, its services and social problems.

Forecasting Delinquency

The April 1956 issue of the *Journal of Education*, published by the Boston University School of Education, is devoted to a discussion by William C. Kvaraceus on the possibilities of forecasting juvenile delinquency. While expressing the belief that not one of the present-day techniques intended to identify the potentially delinquent child early in life has been shown to be infallible, the author suggests that several of these may soon be as useful in this effort as are intelligence tests in identifying children's potentialities for achievement in the classroom. Urging that such techniques be further tested he describes at length several studies designed to test the validity of his own "KD Proneness Scale and Check List," and suggests subjects for additional study.

Hearing and Speech

A description of the teamwork in the hearing-and-speech clinic of the Michael Reese Hospital, Chicago, in the *Journal of the American Medical Association* for July 7, 1956, demonstrates the multidisciplinary approach to helping communicatively handicapped children and adults.

The article discusses the work of four members of the clinic's staff: an otologist, who is the team's medical supervisor; a clinical audiologist and speech pathologist; a medical social worker; and a child psychiatrist. Other specialists on the hospital staff are made available to the clinic when necessary.

The otologist examines the patient and either gives or arranges for medical or surgical treatment. When such treatment cannot improve the patient's hearing, the clinical audiologist and speech pathologist evaluates the condition, and, working with the team psychiatrist, looks into any suspected nonorganic causes of the speech problem. The social worker often helps in resolving any social or emotional problems that are interfering with the patient's maximum adjustment to his hearing and speech condition.

About Wheelchairs

Advantages and disadvantages for a handicapped child using a wheelchair are noted by Drs. A. Kanof and M. T. Koven in the *Quarterly Review of Pediatrics* for February 1956. A wheelchair, the authors say, permits the child to carry on the daily activities of living, encourages recreational and vocational programs, reduces the bad psychological effects of staying in bed, and lessens the physical results of lack of movement, such as muscle atrophy. On the other hand, unless preventive measures are taken, the wheelchair may seem to the child a prison rather than a release, and it may cause dangerous pressure sores and severe contractures at the hips, knees, and ankles.

The article describes the various types of chairs and accessories and their relations to specific disabilities and points to the need for sympathetic and intelligent interest on the part of the physician in prescribing a wheelchair to suit the individual's needs.

Family Social Work

Social Casework for July 1956 publishes a report on the content of family social work, prepared by the Family Service Association of America for the Council on Social Work Education's curriculum study. The report analyzes the services of the family social worker to the client, the agency, and the community, and the skills needed to carry them out. It identifies the basic requirement of the family caseworker as the "ability to understand the social needs of many kinds of people and to deal with a wide range of problems," and stresses the importance of understanding both individual behavior and family dynamics to psychosocial diagnosis and treatment.

Besides the skills needed to work directly with families, the family worker must be able to manage the administrative aspects of his job, to participate in community planning, and to work constructively with groups, according to the report.

READERS' EXCHANGE

NORRIS: *Details to come*

Miriam Norris' report ("The Development of Blind Children," CHILDREN, July–August 1956), the first to be published from the Project for Study of Blind Children, Chicago University Clinics, since the completion of a 5-year study, only touches upon the highlights of a more detailed publication to come in the future; yet it is in itself a rich source of information to all persons interested in blind children and their development. In a field where previous research has been meager, the Chicago study seems to support much of the more impressionistic findings of recent but less intensive studies, at the same time shaking the very roots of traditional thinking in regard to the blind child's potentialities for a full and useful life.

This study emphasizes the complexity of the problem of blindness and the interrelatedness of many of its factors. Miss Norris' description of the blind child's need to reach out while parental attitudes may be working in an opposite direction to fulfillment of this need, is only one example of the findings which should lead to a better understanding of what within the blind child himself and what in the environment affect his growth and development. At the core of the answers to these questions seems to be a "comfortable relationship with the parents," rather than special techniques or skills peculiar to the situation because the child is blind.

Though Miss Norris' article hints at certain social factors considered favorable and conducive to normal sequential development, the reader will look forward to a more specific and concrete delineation of what was observed to foster the development of the blind children studied. The reader will also want to know more about the visual acuity of children who are "educationally" blind and about the implications of even a little vision, only as much as light perception, as contrasted to total blindness, in the functioning of the child.

It is most natural for us to think of the achievement of the blind child in terms of what is known of normal, chronological, developmental levels for the sighted, since this body of knowledge is more familiar to us. However, as our knowledge of all children increases, it is expected that the child who is blind, too, will be evaluated in terms of his own growth patterns and his own individuality. Miss Norris' study is pointed in this direction.

Pauline M. Moor
Consultant in Education, American Foundation for the Blind

Some omissions

There are many interesting observations and statements in Miriam Norris' article. Unquestionably the detailed report of the University of Chicago study and particularly the testing scales it developed will enrich our knowledge and improve our services.

There can be no disagreement with the main points of the study—in fact, they are by no means new but have previously been explored and expounded by others. What strikes one as strange is the author's failure even to mention this fact in a general way. For example, she writes: "Perhaps the most significant finding of the study is that the development of the blind child with no other major physical handicap can be expected to progress in orderly fashion. . . ." This was stated by Gesell more than 10 years ago and confirmed for babies with retrolental fibroplasia at a conference held at Perkins Institution for the Blind in 1952.

There are two important questions which are not mentioned by Miss Norris but may be answered in the full report of the study: (1) Did the study separate children who are partially blind from those who are totally blind and analyze the data accordingly? (2) Did the study recognize the importance of the fact that babies with retrolental fibroplasia are in varying degrees deprived of maternal care during long periods of their first year of life and did it consider the effects which this may have on mother and child? This factor by itself may explain the differences observed between the behavior of many children with retrolental fibroplasia and of those blind from other causes.

There is one statement which contradicts past research and common sense. Miss Norris defines orientation as "the child's ability to get about freely and independently and to relate himself to his environment," and states "According to our findings, skill in orientation seems to bear little or no relationship to . . . degree of vision." Surely, the ability to get about depends to a great extent upon degree of vision. There are marked differences in orientation among totally blind children, but certainly even a low degree of vision makes an essential difference in orientation.

Berthold Lowenfeld
Superintendent, California School for the Blind

OJEMANN: *Analyses needed*

To anyone interested in child development or mental health, Ojemann's research ("Changing Attitudes in the Classroom," CHILDREN, July–August 1956) is an extremely exciting venture. It represents a significant attempt in education to go beyond the usual emphasis in teacher training on "meeting the needs of the child," to an emphasis on making the child aware of motivating forces underlying behavior—in the larger social setting and in his personal relationships.

This seems like such an obvious thing to do—to teach children something about how human behavior works, in the motivational sense. Obvious though it may be, where in the mental-health sciences can we point to systematic studies of the effects of what Ojemann calls the "causal" approach to behavior? This is needed research.

It is important, however, to recognize the limitations as well as the promise in this effort. "Causes" of behavior are not always easily ascertained; wrong "causes" may be concluded; there may be difficulties in accepting causes that apply to one's own behavior and relationships with others. The problem is one which must be handled with sophistication.

How training in the "causal" approach can be accomplished for teachers and children has been elaborated more extensively in other writing by the investigator. He is careful to point out the necessity for distinguishing between surface verbalizations about motivations which may result from the training program and understandings at a deeper level.

Much time and creative effort have gone into the training side of this research. How real, how big, how lasting are the effects? For answers to these questions, the evaluations reported in terms of statistically significant differences on paper-and-pencil tests between control and experimental groups are only first approximations. The real test of the effects must be based on intensive analyses of the spontaneous behavior of the children who have been exposed to this kind of training. Ojemann gives some examples of this kind. It is hoped that there will be further systematic analyses at this level which will provide conclusive findings from the research.

Marion Radke Yarrow,
Social Psychologist, Laboratory of Socio-Environmental Studies, National Institute of Mental Health.

WORK: *In Israel too*

Readers of CHILDREN may be interested to learn of efforts to ease the experience of hospitalization for children in Israel, similar to those in the United States described by Dr. Work ("Making Hospitalization Easier for Children," by Henry H. Work, CHILDREN, May–June 1956). At the Tel-Hashomer Hospital, where before 1952 visiting parents could see their children only through glass windows, the practice of free visiting by parents had to be introduced gradually and be accompanied by conscious efforts to change the attitudes of the staff. Now parents are allowed into the wards whenever they wish to come and there is noticeably a warmer, more friendly attitude on the part of the staff—including doctors and nurses—toward the parents and the children.

The parents while in the ward are under the discipline of the nursing staff, with the nurse in charge the arbiter of complaints and requests. They take care of their own children, with the assistance of the ward nurse who carries out all the medical procedures and helps mothers who are having difficulties to learn how to care for infants. Parents also often voluntarily help other children than their own, especially in entertaining them.

The procedure has not only helped the parents and children but has relieved the nurses of many tasks. It has also helped the young nurses to understand the importance of individual, patient attention, particularly by the mother, in accelerating the recovery of a sick child.

The procedure has also helped the staff to appreciate the cultural positives in those more primitive Oriental groups in the Israeli population. They have seen a pregnant Iraqi mother sit with her desperately ill child day and night for nearly 2 months until she herself began labor and had to be sent to the maternity ward. They have also seen a Yemenite mother, who had five other children at home, sit with her sick child for 4 weeks, although this meant that she lost her employment, the family's only means of support. We have no difficulties in getting Oriental mothers to understand and fit into the ways of the hospital.

The hospital especially encourages regular parent-visiting to children with burns, who are usually suffering extreme fright and pain, and to blind, deaf, or otherwise severely handicapped children.

The presence of the parents has has sometimes revealed incipient difficulties in parent-child relationships, requiring psychological treatment or parent education, which might otherwise have escaped the staff's attention. When possible, such treatment is initiated before the child leaves the hospital.

The negative results some feared from the system have not materialized. There has been no increase in cross-infection. Parents rarely break the rule against giving their children forbidden foods. Instead of interfering with hospital routines, the practice of allowing parents to stay at the bedside during ward rounds often helps the staff to understand the patient and prevents staff remarks sometimes made before children in the often mistaken notion that they can't understand.

The hospital is currently carrying out a study to find out how much visiting is actually done and what it means to the families involved. This will include information on the frequency of visits, the cost of getting to the hospital, the traveling time, and home arrangements for the care of other children.

Bernard E. Cohen, M. R. G. P. E.,
Government Hospital
Tel-Hashomer, Israel

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Frontispiece and pages 170, 173, and 174, United Nations.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five-percent discount on quantities of 100 or more.

SURVEY METHODS FOR DETERMINING THE NEED FOR SERVICES TO CHILDREN OF WORKING MOTHERS. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1956. 48 pp. 25 cents.

This report of a pilot study compares three methods used in estimating how many children of working mothers in a community need day-care centers, nursery schools, school centers, or foster-family day care. The study was made by the Community Planning Council of Wichita, Kans., with financial help from a foundation and technical help from a committee representing several Federal agencies.

CHILDREN'S BUREAU STATISTICAL SERIES. Single copies available from the Bureau without charge.

Personnel in Public Child Welfare Programs, 1954. No. 30. 1956. 14 pp.

This report shows that 4 percent more professional workers were employed in public child-welfare programs in 1954 than in 1953; 2 percent more counties had the services of at least one full-time child-welfare worker; caseworkers' salaries rose by 4 percent; vacancies were 11 percent fewer, but close to 10 percent of all professional child-welfare positions were vacant in June 1954.

Children Receiving Casework Services, June 1954. No. 32. 1956. 12 pp.

About 415,000 children in the United States were receiving casework services from public and voluntary child-welfare agencies, this report estimates. Sixty-four percent were served by public agencies, 36 percent by voluntary agencies. Both voluntary and public agencies markedly increased the number of children served in adoptive homes—18 percent and 14 percent, respectively.

STUDIES IN JUVENILE DELINQUENCY; a selected bibliography 1939–1954. U. S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. A limited number of copies available without charge from the Bureau.

This bibliography, covering the period January 1939 through December 1953, was compiled by Otto Pollak and Norman Johnston of the University of Pennsylvania's Department of Sociology from *Psychological Abstracts, Index Medicus, Current List of Medical Literature*, and a number of individual journals in the fields of criminology or sociology. Sections on trends in volume and character of delinquency; causation; treatment (the largest section); prevention; research methodology; and methods of quantitative research include more than 450 titles.

MENTAL HEALTH MOTION PICTURES, 1956. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. No. 470. Supplement to PHS Pub. 218. 1956. 80 pp. 30 cents.

This supplement to "Mental Health Motion Pictures," published in 1952, describes 78 films that have been issued since then.

JOB GUIDE FOR YOUNG WORKERS, 1956–57 edition. U. S. Department of Labor, Bureau of Employment Security. 1956. 67 pp. 40 cents.

For 110 occupations requiring no more than a high-school education, this bulletin lists employment prospects, qualifications, usual duties, opportunities for advancement, how and where job is obtained, and characteristics of job.

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Children and Radiation

Unmarried Mothers in Hospitals

Protection From Tooth Decay

Child Rearing and Mental Health

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Whether or not this little girl is building up strong teeth as she quenches her thirst depends a lot on where she and the drinking fountain are. If the town's water supply contains 1 part per million of fluoride and she keeps on living there she will have one-third as many cavities as she would if she lived in a town where the water contained a substantially lesser amount of the fluoride ion or none at all. (See page 219.)

Protecting water-supplies from pollution has long been a function of public health departments. Broadening this safeguarding responsibility to include correcting a fluoride deficiency, hundreds of communities in recent years have been adding fluoride to their water supply to help their children build strong teeth.

◄ *the authors*

Before taking his present position, Dr. Robert W. Miller was chief of pediatrics with the Atomic Bomb Casualty Commission in Hiroshima, where he studied children who had been exposed to radiation from the atomic bomb. A former AEC fellow in radiation medicine, he spent 2 years on the staff of the University of Rochester Atomic Energy Project.

A medical student before her marriage, Lucile G. Boole eventually combined an interest in medicine and social service by becoming a medical social worker. A graduate of Simmons College School of Social Work, she worked for a year at the Massachusetts General Hospital before going to the University of California Hospital. There she first worked in the Obstetrics and Gynecology Service.

Lois Barclay Murphy's distinguished background of research and teaching in child psychology has included service at Sarah Lawrence College in New York, Gujarat University in India and the William Alanson White School for Psychiatry. She is author of a number of research publications on personality development in children.

Initiator of the dental-carries fluorine study he describes here, Dr. David B. Ast has been with the New York State Health Department since 1938 except for a 2 year leave of absence. While away then he served as chief dental officer for the Joint Distribution Committee and assisted in establishing dental care programs for displaced persons in Europe.

Before going to St. Louis in 1949 Herbert Domke (right) was chief medical officer for the Chicago Health Department. His collaborator A. D. Buchmueller, (left), a psychiatric social worker, has taught at both the medical and social work schools of George Washington University and has served as part-time director for the St. Louis Council for Parent Education.

A graduate of Boston University, School of Social Work, with advanced training from the University of Chicago, Richardson Rice has worked in children's institutions in Boston, Detroit, Syracuse, and Freeville, N. Y. In addition to directing the New England Home, he teaches social work at Boston University and Simmons College.

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Great Britain's and the United States' most authoritative scientific organizations alert health workers to the need for . . .

SAFEGUARDING CHILDREN FROM RADIATION RISKS

ROBERT W. MILLER, M. D.

Professional Associate, Committee on Atomic Casualties, National Academy of Sciences—National Research Council

ON JUNE 12, 1956, there appeared the first of a series of publications issued by six committees of United States scientists called together by the National Academy of Sciences—National Research Council to review comprehensively the biologic effects of nuclear and allied radiation.[1] Simultaneously the British Medical Research Council presented to Parliament its report on the same subject.[2]

These scientific groups were composed of individuals who are among the most learned in their countries in the various fields of medicine and in the basic sciences as they relate to radiation[3] effects. They evaluated the mass of scientific information on radiation effects in man and the sources of radiation exposure. The results of their deliberations are available to anyone who desires copies.

The British panel for the review of genetic effects was made up of 7 scientists and the American group of 18, 16 committee members and 2 consultants. For the study of the effects of radiation on the health of the individual, the British panel was composed of eight scientists. In this country the corresponding Committee and Subcommittee on Pathologic Effects of Atomic Radiation had 49 members and 8 consultants. The American report also contains the findings of other committees concerned with estimating present and possible future contamination of air, sea, and land with radioactive materials from atomic industry and weapon testing.

Both the American and the British reports concluded that the genetic effects are the determining factor in establishing man's allowance for whole-body radiation. They pointed out that information derived from experimentation on fruitflies and mice indicates that mutant genes, unlike other radiation-induced damage, are produced by even the smallest exposure of the reproductive cells to radiation. While little is known directly about the effects of radiation on human genes, the patterns of genetics are generally thought to be the same for all forms of life which reproduce sexually. In all but the very rarest instance, radiation-induced mutations are detrimental, according to the reports. In the next generation, or in generations farther in the future, they may cause or contribute to the occurrence of miscarriages, congenital malformations, or, more subtly, increased susceptibility to certain diseases.

Radiation-induced genetic mutations are of concern only when they take place in the gonads of individuals who are in the childbearing age or younger. The reports' recommendations for minimizing radiation exposure in medicine and dentistry apply, then, most particularly to those responsible for the medical and dental care of children and young adults.

The United States and British scientists both concluded from their reviews of current genetic theory that *for the population as a whole* the average accumulated dose of radiation *to the gonads* should not exceed 10 roentgens from conception to the age of 30 years. About half of the children in the United States are born to parents under 30, nine-tenths to parents under 40. This allowance is for radiation

HOW ARE professional organizations responding to the call for alertness to radiation hazards in the reports reviewed in this article? Replies to an inquiry from CHILDREN showed interest, some fear of public misunderstanding, and various publicizing activities.

The American Medical Association plans "a review study of the material from the National Academy of Sciences and other sources," and the American Academy of General Practice will cooperate with the AMA. The American Academy of Pediatrics has published articles and editorials giving the reports' findings and urging caution in the medical use of X-rays and radioactive materials.

The American Dental Association has published an editorial in its journal which while referring to "apprehension" among patients as a result of the reports, advises dentists to heed its recommendations. The American College of Radiology, while approving of the report of the National Academy of Sciences insofar as it furthers "continued education" on radiation hazards maintains there is "room for discussion" as to the "validity of some of the inferences . . ."

The American Public Health Association, in a brief editorial in its journal, has particularly emphasized the significance to health officers of the reports' warnings on the dangers of radioactive industrial waste.

The source of the American report, The National Academy of Sciences—National Research Council, has sent out 40,000 free copies of the report and is planning further studies and discussions on radiation hazards.

exposures in excess of that from the natural environment to which man has always been exposed.

Both scientific groups recommend that *for the individual* the dose of radiation accumulated by the reproductive cells in the first 30 years of life should not exceed 50 roentgens. The British scientists add that not more than one individual in 50 should receive this maximal permissible dose.

These figures are based on today's best estimate of the impact that a 20-percent nationwide increase in the number of mutant genes would have on the health and development of the descendants of today's population in the United States.

Radiation produced by X-ray and fluoroscopic diagnostic practices in medicine and dentistry is the greatest *present* threat to our population's allowance for safety, according to these reports. They point out that while little is known of the delayed fallout of radioactive particles that are stored in the stratosphere as a result of testing large nuclear devices, the dose received from *external* radiation of fallout from nuclear test weapons *at the present rate of exposure* is negligible. Medical and dental X-ray procedures in the United States now exhaust from 3 to 4 of the 10-roentgen limit, as defined above. Again the reader is reminded that these figures are averages for the dose acquired by the reproductive cells of the population as a whole.

That the most ordinary diagnostic medical and dental X-ray exposures can be additive throughout the life of the patient is a relatively remote concept to most practitioners of medicine. In this age when machines and substances that emit radiation are used more and more commonly in medicine, in industry, and by the military, it is urgent that man's tolerance be dissipated as little as possible, and from the very start of life. Who can tell which of today's babies will, 25 years from now, be exposed frequently to X-ray machines when, in adulthood, they work as doctors, dentists, nurses, technicians, or attendants? Which of these babies will later be the factory workers inspecting golf balls with the use of fluoroscopes, or the men who mine uranium, or the people working near nuclear power generators?

For the individual, how much of the scientists' recommended maximum permissible dose of 50 roentgens, accumulated by the gonads in the first 3 decades of life, is spent as the patient undergoes various radiologic tests?

Very little of the radiation that is directed to the individual's chest, head, arms, or lower legs reaches his reproductive cells. Some, however, does reach the gonads by the scatter that occurs when the radiation is deflected by bone or by structures near the patient. Reproductive cells may be directly under the beam of the X-ray when radiologic studies are made of the hips, spine, pelvis, or abdomen.

When one X-ray film is made of the abdomen, the dose to the skin of the patient at the point where the radiation enters his body is about 1.2 roentgens, varying with the technical X-ray factors used. If the testes are included in the radiation field, they may receive virtually the full skin dose. As the radiation passes through the tissues some of it is absorbed, so that deeper organs receive a smaller dose. Because the ovaries are partially shielded in this manner, they are subjected to perhaps one-sixth of the skin dose. Some radiologic studies, such as the intravenous pyelogram, require a series of X-ray films of the pelvic region.

The expenditure of one's allowance for radiation is greater when fluoroscopy is used than when an X-ray film is made. In fluoroscopy, the patient's skin facing the beam of X-rays may receive between 2 and 100 roentgens per minute, depending on the output of the machine used and the distance of the patient from the source of radiation. The usual dose, however, is 10 to 20 roentgens per minute. The area under examination is customarily exposed for 2 to 5 minutes. The testes are not likely to be included in the fluoroscopic field except when abdominal studies are performed on infants and small children, but in all fluoroscopic procedures the reproductive cells receive some scatter radiation.

In the past when X-rays or fluoroscopic studies have been made of the abdominal or pelvic region or of the hip it has not been common practice to protect the testes by placing a layer of lead between this organ and the radiation. This usually would not alter the diagnostic value of the roentgen procedure. Yet even in some of the best hospitals in the United States today, the value of this simple protective measure is not recognized. Methods are being investigated for shielding ovaries without obstructing the view of the organs under study.

Because many physicians have seen no clinically detectable ill effects in their patients, the concern that geneticists have expressed has seemed to many practitioners in the past to be of small consequence. The present reports may improve the understanding, and consequently the practice.

What are some of the precautions that should be taken in the future?

The observations that follow are the present author's interpretations, drawn from the radiation literature [4, 5] and from clinical experience,[6] of the implications of the British and United States reports.

When radiation is administered by a well-trained person, there is no acute hazard to the patient.

X-ray films should be obtained, of course, whenever it is a matter of medical necessity, but under all circumstances the patient should receive the smallest exposure that will provide adequate diagnostic information. There should certainly be no limitation of the use of properly administered roentgenologic procedures for the early detection of diseases that would otherwise elude recognition. Thus, survey films for the identification of early tuberculosis, cancer, and other diseases commonly detected by X-ray in properly selected groups are not to be discouraged.

When a radiologic examination is needed, an X-ray film should usually be obtained initially. After the survey film has been secured, a fluoroscopic examination can be made, if it is required, to obtain more information about the abnormality. This would preclude the use of fluoroscopy routinely as part of the monthly examination of the infant in the first year of life, a rather common practice in certain parts of the United States.[7]

In clinical practice, as distinguished from clinical investigation, X-ray is sometimes used for the prevention or treatment of disease without adequate scientific proof that it is beneficial. For example, an occasional physician has subjected all newborn infants coming into his practice to prophylactic radiation of their thymus glands in the belief that this increases the child's resistance to infection. There has been no well-designed clinical study to substantiate this belief. Studies have been made which suggest that children whose "enlarged" thymuses are treated by radiation early in life have an increased incidence of cancer of the thyroid and of leukemia in the next 2 decades.[8]

Irradiation of the ovaries for the relief of sterility in women, which usually involves a dosage of 50 to 90 roentgens, has been widely practiced by several gynecologists and enthusiastically recommended to the medical profession by them.[9, 10] They have apparently not contrasted the results they obtained in the radiation-treated women with those in a sham-treated comparable group observed concurrently in a "double-blind" study: that is, one in which neither the attending physician nor the patient knows which procedure is used. It may be that the preparation for the X-ray treatment evokes an emotional response in the patient that makes pregnancy possible. If this is the case, an equally effective device may be found to produce the same results without administering radiation and so spare the descendants of these women an extra load of mutations.

Nongenetic Effects

The nongenetic effects described in the following paragraphs are from the American and British reports. Descriptions of the mechanisms by which these changes may be produced are from the reviews of the literature.[5, 6]

Most of the disabilities caused by radiation-induced mutations will not make their appearance until several generations after exposure, and so are not likely to be a matter of real concern to most people. Of more immediate interest, perhaps, is the threat to the health of our own generation from excessive exposure to radiation. To determine what immediate or delayed effects there may be to the living and to their immediate offspring, one must examine information derived from animal experimentation, from the accidental overexposure of human beings, and from the survivors of the atomic bombs in Japan.

The sum of these experiences indicates that *nongenetic* radiation-induced disease does not become clinically apparent until a threshold has been exceeded. Lesser exposures fall within the range of tolerance and the subject experiences no noticeable ill effect. If the radiation dose is not a lethal one, the nongenetic damage to the body is usually repaired within a few weeks of its occurrence, but this recovery may be incomplete. Some malfunctioning cells may apparently lie dormant for years. Then, when some other change in the patient's body or environment occurs, the malfunction worsens or the number of defective cells increases until finally a clinically recognizable disease develops. Since the injury sustained by a series of exposures may be cumulative throughout life, each repetition of injury may hasten the approach of the threshold for late effects.

Animal experimentation has shown that at certain times in pregnancy some of the organs of the embryo are especially susceptible to the effects of radiation.[11] This has been confirmed in the human being. In Hiroshima and Nagasaki, women who were heavily exposed to the bomb when they were between the 7th and 15th weeks of pregnancy gave birth to children who suffered mental retardation associated with a smaller head circumference than normal.[6]

Children are thought to be more susceptible than adults to the delayed effects of radiation because rapidly dividing cells are generally more susceptible to such damage produced by this physical agent. In addition, because of their longer life span, children are more likely than adults to survive the latent period of the delayed sequelae.

The study of the atomic bomb survivors in Japan shows conclusively that the incidence of leukemia in man increases as the result of single large exposures of the whole body to radiation. It has been reported that the incidence of this disease among radiologists in the United States is nine times greater than among physicians who are not radiologists.[12] If further studies substantiate this, it would mean that very small daily radiation exposures *of the whole body* can also produce this disease in the human being. The medical literature contains accounts of an increased incidence of leukemia among children given radiation therapy for enlargement of the thymus gland,[8] and among adults who have received irradiation of the spine for rheumatism.[2] If these are confirmed by additional studies, one would conclude that *partial* body exposures to therapeutic doses of X-rays can also induce leukemia.

Premature aging is a late sequel of radiation which has been found in laboratory animals but has not yet been conclusively demonstrated in man. The shortening of life that occurs is proportional to the dose of radiation given. The animals grow senile when they are only middle-aged, and their deaths are caused by the multiplicity of diseases that ordinarily beset the elderly members of their species.[13]

While these observations suggest that the human population as a whole may have a liberal margin of safety for delayed effects of radiation other than genetic mutations, the minimal dose level for producing these changes in any individual is unknown. It probably depends on his natural resistance to radiation and on the influences of other changes in his environment—diseases, drugs, aging, more radiation. Conceivably a combination of factors could cause an occasional individual to be unusually susceptible to the effect of radiation.

While it is extremely unlikely that medical or dental diagnostic X-rays, when properly administered, will precipitate any of the nongenetic late effects, cumulatively they may shrink a patient's tolerance so that he will be less well able to withstand an unavoidable exposure to radiation in the future.

Current Radiation Protection

There are physicians, particularly radiologists, who endeavor to protect their patients and personnel from the possible late effects of X-rays. They have devised radiologic techniques that lessen the area of the body that must be exposed, the time that the patient is subjected to the X-ray beam, and the dosage output of roentgen-ray machines. However, the operation of many X-ray devices is not under the supervision of individuals properly trained in radiologic procedures. It is in these instances that unnecessary exposures are most likely to occur. The recommendations of the Committee on Radiation

Protection, of the American College of Radiology, may not reach a large portion of individuals using X-ray equipment.

The gains that can be made to diminish unnecessary radiation exposure are exemplified by the history of fitting children's shoes through the use of fluoroscopy. Physicians pointed out that shoes could be equally well selected without the use of this procedure, in which the output of the machines was often needlessly high, shielding was inadequate, and exposures were prolonged or repeated because of the interest of the children. In some States laws have been passed which bar or limit the use of fluoroscopes for this purpose. Five years ago they could be seen in many shoestores. Now they are disappearing.

A Challenge to Health Workers

It has been recommended by the aforementioned British and American scientific groups that roentgen-exposure diaries be kept for each person. This would enable the physician in the community, in the armed forces, and in industry to be conscious of the accumulation of X-rays already absorbed by the patient. It is recommended that to conserve one's tolerance to radiation as much as possible, doctors and dentists use X-rays only when it is "consistent with medical necessity" to do so, and then to use the least dose that will give satisfactory results. Although as leading physicians declare, keeping an exact account of the dosage received by every individual may be impractical, perhaps a list of each patient's roentgen-ray exposures would help his own physician to be aware of the record to date.

To achieve a reduction in radiation exposure, it will be necessary to impress physicians and dentists with the need for doing so. The writings of individuals on this subject do not carry the balance and authority possessed by the groups of British and United States scientists mentioned earlier in this paper. With the publication of the findings of these expert committees, an opportunity has been given to the medical and dental professions to implement the recommendations made. Scientific groups must now decide the extent to which the known facts should govern radiologic procedures as they are employed by each of the medical specialties and in dentistry. This applies both to the mechanics of using radiation devices and to the purpose for which they should be used. Scientists must advise on measures to be taken to familiarize students in professional schools and practitioners with this information. They must identify the gaps that exist in the understanding of radiation effects and provide the stimulus for undertaking laboratory and clinical investigations that will dispel the uncertainty and increase our knowledge.

On the subject of late radiation effects, the most authoritative scientific organizations in both the United States and Great Britain have set the stage and raised the curtain. The remainder of the performance is the responsibility of all professional health workers, particularly those concerned with children.

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[1] National Academy of Sciences—National Research Council: The biological effects of atomic radiation; (a) A report to the public, (b) Summary reports. Washington, D. C. 1956.

[2] Medical Research Council: The hazards to man of nuclear and allied radiations. London: Her Majesty's Stationery Office. June 1956.

[3] Radiation, as the term is used in this presentation, refers only to *ionizing* radiation.

[4] Miller, R. W.: Radiation injury. Pages 1480–1482. Nelson, W.: Textbook of pediatrics. Philadelphia: W. B. Saunders, 1954.

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[12] March, H. C.: Leukemia in radiologists in a 20 year period. American Journal Medical Science, September 1950.

[13] National Academy of Sciences—National Research Council: Pathologic effects of atomic radiation; report of the Committee on Pathologic Effects of Atomic Radiation. Pub. 452. Washington, D. C. 1956.

THE HOSPITAL AND UNMARRIED MOTHERS

LUCILE G. BOOLE, M. S.

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THE GIRL "in trouble" often turns first to a doctor or a clinic to confirm pregnancy—in some instances early, in others only shortly before term. Whether her reaction is one of silent withdrawal, apparent indifference, or obvious panic she needs immediate help. Though her initial contact with the hospital may be fraught with psychological hazards, the service it gives her may be a decisive factor in the general course of pregnancy and in her decision concerning her baby.

All the services a hospital can offer to an unmarried pregnant woman may be overlooked under the pressure of her immediate medical need. When brought into the picture early enough a hospital can play an active and positive role in converting a potentially devastating experience into a less traumatic one for the mother.

The policies and procedures of maternity service at the University of California Medical Center in San Francisco illustrate how the hospital can assume a positive, dynamic role. The Medical Center is primarily a teaching institution for students in the schools of medicine and nursing. Through its social-service department, it also offers fieldwork experience for social-work students in their second graduate year.

The hospital accepts maternity patients on "staff" service as well as those under the private care of faculty members. "Staff status" designates the patient who is financially unable to pay for private medical care and, for a small flat fee, has all-inclusive maternity service provided by members of the resident house staff under the supervision of the senior faculty. The "private" patient selects her physician from among the faculty, pays full hospital rates, and private fees. The facilities of a rooming-in unit are available to both "staff" and "private" patients, including the unmarried mother, if she desires it and if space is available.

In 1955 the Medical Center was the setting of 1,147 deliveries, 20 percent through private and 80 percent through staff service. Of the mothers, 191 were known to be women pregnant out of wedlock. Among the latter were patients accepted from the Florence Crittenton Home in San Francisco, for whom the university provides, at a nominal fixed fee, the same prenatal, delivery, and postnatal care as for other staff patients.

There is no typical patient among these women. The age range is wide. While the majority are in their late teens or early twenties, a substantial number are between 12 and 15 years of age at the time of delivery and others are as old as 37 to 43. Thus, the word "girl" is not always applicable, nor is the word "woman."

A further obstacle in the use of descriptive nouns and adjectives is the variation in marital status. Most of the patients have never been married; some have been married but are now divorced, are in the process of being divorced, or are separated from their husbands and illegitimately pregnant. A few married couples ask for guidance in releasing the expected baby for adoption.

The patients vary in race, religion, economic status, and educational accomplishment. Most of them are unable to pay for private medical care and are on staff status. Many of these are nonresident girls who have resisted applying to the county hospital for care because of its policy of writing back to the home county for verification of residence and payment through public welfare funds. Both private and county agencies in the San Francisco Bay area are trying to make available the financial help needed to carry such girls through their pregnancy and a reasonable period of convalescence, with the hope that they will not feel forced into plans they do not want to make. The agencies are also concerned with girls who have legal residence but are unable to pay medical costs.

Approach to the Patient

At the Medical Center the aim is to provide the best possible medical care through recognition of the interrelationship of medical, social, and emotional factors. This requires the harmonious cooperation of the various members of the hospital staff and is based on an understanding and respect for one another's work. To accomplish this aim the senior medical staff and the administrative staff have issued clear precepts for the approach to the unmarried mother. These are based on procedures and concepts evolved by doctors, nurses, social workers, hospital administrators, admitting clerks, and secretaries in their attempts to offer good medical care and provide counseling service to patients who will accept it. These precepts also protect the interest of the hospital and the inviolability of the doctor-patient relationship.

In its approach to women pregnant out of wedlock the Center attempts to assure the patient of acceptance without prejudice or discrimination, without segregation or isolation, unless isolation is medically or emotionally indicated. Confidential information is respected, and every effort is made to maintain strict observance of ethical standards. The patient's right of self-determination is acknowledged, and the services of a trained social caseworker are offered.

The patient is informed of what the hospital can offer her and what it expects of her. Unless the limits of the hospital's responsibility are made clear, some patients might continue to deny the reality of their situation, become enveloped in their ambivalence, fail to make any plans, or find themselves thrust into unwise solutions. We recognize that any patient may change her plans after her child is born, but believe that tentative plans worked out in advance offer some protection to both mother and child.

In order to assure a full range of service and protection, the medical social worker on the obstetrical service tries to secure some knowledge of each patient who is pregnant out of wedlock and to cooperate with the various community agencies. Often a family agency sends a girl to the hospital for medical care; or the girl comes to the hospital first and is referred by the medical social worker to a family agency for help with the nonmedical aspects of her problems. In either case, division of the casework responsibility is determined by agreement between the social workers. Similar agreements are made with the casework staff of the various adoption agencies, with whom harmonious working relationships are essential.

The painstaking orientation which falls to doctors, nurses, and the social worker is aimed toward helping the patient make the best use possible of her hospital experience. From the first visit in prenatal clinic, she is called "Mrs." and is treated the same as other patients, unless her emotional state requires deviation from staff procedures. Once her initial apprehension is allayed, she usually fits into the routine easily.

The orientation includes a private interview with the head nurse who discusses general aspects of maternity care. On a subsequent visit, the patient may join a group hospital tour to the admitting office, the emergency unit, the labor rooms, bedrooms, and nursery. She is invited to attend the clinic classes on child care. After delivery, if she wishes, she may go to the daily talks and demonstrations for new mothers. Many of the girls go to the classes even though they are releasing their babies.

The Medical Social Worker

When an unmarried expectant mother is sent to the hospital by a community agency, when she applies to the admitting department for registration in the prenatal clinic, or when a nurse or examining physician learns that she is pregnant and unmarried, she is referred to the medical social worker. The referral is made in order to protect both the patient and the hospital.

The referral is made in order to protect the patient from last-minute decisions, and the hospital from the disruption involving the entire staff when a patient reveals total lack of planning for her baby. Since the assignment of a social worker to the obstetrical service, the hospital has not had to request the juvenile court to accept custody of a baby and only rarely to ask emergency foster care from an agency.

The social worker's first effort is toward gaining enough information to be able to assure the patient that there are sources of help open to her, to offer services to alleviate some of her worry, and to help make plans for herself and her baby. The right of the patient to formulate and execute her own plans is acknowledged.

Only a single interview may be required or there may be considerable activity, ranging from a few rather intensive interviews to long-term contact. Often, referral to a family agency, to an adoption agency, or to a maternity home is accomplished.

On the private service, the senior staff physicians may refer patients to the social worker at their discretion. Occasionally, they may request casework services for a patient to help her arrive at a decision on whether to keep or release her baby; sometimes, they will ask the social worker to help get underway plans the patient has made herself. The private patient, while not under the same financial stress, may have the same worries as the staff patient in relation to her situation and suffer the same doubts and vacillation about whether or not to see her baby or whether to release him for adoption, and feel the same concern about filling out the birth certificate.

Procedures

Once information about the patient has been secured, either by personal interview or from interested agencies, cards are sent to the head nurses in the delivery room and on the obstetrical floor, conveying enough information about the patient's probable decisions to help them understand her worries and cooperate in carrying out her wishes. Giving a thumbnail sketch of the patient's problems and tentative plans, these cards protect the patient from repetitious questioning by doctors and nurses as she enters the hospital and goes through labor and delivery. Her plans can swing into action with a minimum of effort. If she has decided to release the baby to an agency, the agency is notified when the birth takes place, and nursery and agency keep in touch with each other until the time of the baby's discharge.

The social worker maintains a close liaison with the doctors and nurses in the obstetrical and pediatric service since at this hospital the pediatricians care for the newborn infants. She is also available to give support to the patient in any crisis in her prenatal course, in the labor room, or during her postpartum stay. If the baby is being released to an agency, the medical social worker can do much to avoid a crisis on the day of separation through the rapport she has established with the patient, and through interpreting to the staff the reasons for some of the patient's behavior.

The patient is always informed of the day and approximate time her baby will be released; she may want a last look at him in private, or a chance to hold him in her arms. If the social worker has helped to prepare her for physical and psychological separation, and has evaluated the patient's probable emotional reactions, then she can gear her own activity accordingly. Her very presence in the room with the patient may be a help.

Even though the mother has made decisions in advance, she is not bound inflexibly to them. Having previously decided not to see her baby, during delivery she may have been aware of much of the childbirth process, heard the baby's cry, and caught a glimpse of him immediately after birth. This may make her change her mind about wanting to see the baby even though she will not breast or bottle feed.

The head nurse in the nursery plays an important role at this stage, since she is responsible for the conduct of the graduate nurses, the student nurses, and the aides who take the babies to the mothers for feedings, who show the babies to visitors, and who are in intimate contact with the mothers. This key nurse must be a good supervisor who conveys the importance of cultivating a sensitivity to the mother's behavior and of interpreting her reactions. She must also help teach her staff to understand why they should not ask unnecessary questions or impose their own feelings, wishes, or judgments on the patient. Above all, she must be a guardian of the ethical standards which prohibit an employee of the hospital from becoming involved in placing an infant for adoption.

These qualities must also be present in the head nurses in the other parts of the hospital through which the unmarried mother goes, from clinic registration to obstetrical floor and delivery room. The supervising nurses play an important part in the selection of personnel who can give warm, accepting care but avoid personal or illegal involvement with plans for the baby. All other hospital-staff members—doctors, secretaries, and social workers—must, of course, also be meticulous in their respect for the patient as an individual, and in their observance of the law.

Birth Certificates

The unmarried mother who is trying to avoid facing her situation, or who is uncertain as to whether or not she will keep her baby, may be helped to understand some of her own feelings and to realize that the baby will be an actual person when she learns that she will be presented with a certificate to fill out on the day after his birth. Many girls are unaware of this requirement.

The mother should know the dangers and pitfalls of false information placed on the birth certificate. She must also have the positive assurance of the protection which an honest birth certificate gives to her and to the baby, whether or not she is going to keep the baby.

During the prenatal discussions the social worker may point out California law permits the mother to choose the baby's surname. The California birth certificate does not ask the direct question about legitimacy or illegitimacy, but it does reveal the marital status through the mother's signature. If the signature of mother matches the maiden name given in the birth certificate, it is *a priori* evidence that she is unmarried.

The possibility that the birth certificates might carry the stigma of illegitimacy for her child worries many a mother who intends to keep her baby. A mother may plan to marry the baby's father or be so angry with him that she refuses to admit his paternity by placing his name on the birth certificate. This privilege of omitting information about the father of the baby also offers some comfort to a woman still uncertain in her decision. In California an affidavit for insertion of omitted information is apt to be easier to provide than one for change of information.

Release for Adoption

The California Civil Code, section 224q, reads:

> "Any person other than a parent or any organization, association, or corporation that, without holding a valid and unrevoked license or permit to place children for adoption issued by the State Department of Social Welfare, places any child is guilty of misdemeanor."

The provision that a parent may place his or her child for adoption often leads to a difficult situation. We have found generally that persons who arrange for private adoptions are not aware of the importance of flexibility in plans and do not recognize that giving birth to a child is a psychological as well as a physical process. All too often, those who are instrumental in arranging the adoption do everything they can to prevent the mother from changing her mind.

A decision made early in pregnancy to release the baby may have been based on what seemed to be the "only intelligent thing to do," without taking into account the psychological changes which come about as pregnancy progresses. The girl who has made a plan early in pregnancy, who has accepted money for payment of her medical care or perhaps even for living expenses, and who may have been told that such acceptance of money constitutes a moral, if not legal, obligation to adhere to her decision, is in a tragic plight if she finds herself unable to part with her child after its birth, or if circumstances in her life have changed.

Often the girl has all arrangements made with a lawyer or, more rarely, a minister, and sometimes she even knows the potential adopting parents before she comes to the hospital.

In such instances the medical social worker helps to expedite release of custody of the child, by giving the mother information concerning her rights and privileges under the law—especially in those instances where the mother's information is hazy, vague, or inaccurate—and by conveying to the lawyer or the prospective adoptive parents the procedures to be followed on the baby's discharge. The adopting parents are encouraged to come to the hospital and talk to the pediatricians and nurses about the baby's eating and sleeping habits, his formula, and his general physical condition, to witness the removal of the baby's identification necklace, and to affix their signatures to the infant-dismissal form which is required by the hospital and also the State Department of Social Welfare. If they change their minds and decide not to accept the promised baby the physician and social worker act promptly to draw in the appropriate community agencies for planning immediately with the mother for the infant's care when he is ready to leave the hospital.

By the time the adopting parents arrive at the hospital the infant-dismissal form, giving the mother's consent for release of custody of the baby to designated persons, has already been signed by the natural mother. The original copy is forwarded within 24 hours to the State Department of Social Welfare. Designed to circumvent unethical practices which have developed in some private adoptions, this form provides a measure of protection to all parties concerned—the child, the natural mother, and the prospective adoptive parents.

If the mother has had an opportunity to discuss with the hospital staff the arguments for and against registration under an assumed name, the advantages of an honestly prepared birth certificate, the safeguards to herself and her child in the execution of the infant-dismissal form, she may come to regard these tools as a help in working out a good adoption plan.

The social workers and nurses do not enter into any process of evaluation in the private adoptions—either on behalf of the natural mother or the adopting parents. However, the social worker is prepared to give counsel to the mother who is emotionally upset, who is wavering in her decision, who does not have knowledge of all resources open to her, who may have inaccurate or incorrect information about the whole adoption process, and who wishes to discuss her situation. The interviews are always carried out with the concurrence of the doctor, or at his request. In them, the social worker helps the girl to clarify her turmoil by giving her factual information and by offering general casework services.

The unmarried mother, like any other patient, has the right to confer with a lawyer if she wishes. Our experience has shown that if the patient has been given frank explanation of the release procedure and if the position of the hospital staff has been made clear to the lawyer, such a conference can be conducted in formal dignity. Occasionally a mother changes her mind about giving up her child and experiences considerable anxiety when pressed by an attorney or an acquaintance. In such an instance the staff doctors may exclude all visitors.

Similarly, on the exceptional occasions when persons have tried to force themselves on a patient, the chief administrator has barred all visitors after he has been informed by the doctor, nurse, or social worker. A statement to the patient from the hospital staff that she does not have to see any person unless she wishes can be both comforting and protective.

The smooth operation of these procedures requires staff knowledge of hospital policies and of the extent to which the senior doctors and administrators will support the orders. In practice, such crises are infrequent largely because of the social worker's efforts to see each girl as early as possible in her prenatal course, to let her know the kind of help available to her, and to be alert to the first signs of trouble. A social worker, like a doctor, answers the call for service on weekends or evenings if conditions demand.

A psychiatrist, functioning as an integral part of the department of obstetrics and gynecology, helps the doctors, nurses, and social workers understand problems or behavior of individual patients and deals with psychiatric emergencies. He may see the patient for a single interview or in therapy over a prolonged period. His help in consultation or direct therapy often plays a decisive role in the unmarried mother's plans.

The woman who is pregnant out of wedlock, or the woman legitimately pregnant who decides to release her baby, provokes a wide variety of feelings on the part of the personnel within a hospital. Some may feel pity or compassion which may lead to undue involvement with the patient. Others, shocked, may insidiously exhibit an attitude of condemnation. Sometimes doctors, especially those new to the service, have considerable subjective involvement and may be inclined to give ready advice to a mother to keep or release her child. Those in supervisory capacity must be constantly alert to the way in which subordinates view and treat patients, and must set the tone of the clinic, conference, or hospital floor by their own example. They must also be aware of their own feelings.

Staff Understanding

The importance of staff understanding requires a constant process of teaching. The senior staff and the social worker, on an individual case basis, try to convey their conviction to the house staff that each girl must make her decision in view of her particular situation, which may involve many complex factors—some of them unconscious. The social worker also holds weekly group conferences with the student nurses and focuses on the psychological, social, and legal aspects of unmarried motherhood. Her exchange of information with staff nurses and members of the medical house staff is more apt to be in vis-a-vis discussion concerning an individual patient. Her written record, which is part of the unit medical record, is a means of conveying information and points of view on policies, attitudes, and concepts to staff members not reached by personal conference, especially those on evening and night shifts.

In summary, the maternity care which the Medical Center provides for a woman pregnant out of wedlock includes a recognition of the social and emotional factors affecting her. Built on clear statements of the senior physicians and administrators this policy encompasses the services of the doctors, nurses, social workers, and secretaries. Requiring a bold facing of many difficulties, it is carried out with strict observance of the legal, ethical, moral, and humanistic aspects of the problem.

Complexity of patterns and cultures in our society require multiple answers to the question of what are the . . .

EFFECTS OF CHILD-REARING PATTERNS ON MENTAL HEALTH

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WE HAVE MORE of almost anything you want to mention than any other country in the world—more property, more gadgets, more food, more science, more medicine, more vitamins, more music, more school—but we don't have better mental health or freedom from problems.

Longitudinal studies like those of Jean MacFarlane[1] at Berkeley demonstrate for the generation she studied in a carefully selected sample that "behavior of the child's needs and of the relation of the culture problems," as we conceive them in professional work with children, are normal for normal children in a moderate-sized city. If by problems we mean enuresis, speech difficulties, tempers, nail biting, transitory lying or stealing, no child grows up without any problems. However, since these problems often bother parents more than children, and since they are often outgrown, they do not as such reflect seriously on our children's mental health.

Neurotic disturbances can be inferred only from prolonged or severe problems, an accumulation of more than one, interference in development, or a child's failure to participate in the life of his age group. Maladjustments to society, expressed in delinquency or character disorders, and the more blatant difficulties in growing up which we see in borderline-psychotic and psychotic children are rooted in multiple pathological conditions, interactions between vulnerability in the child, disturbance in the family, and other stressful experience.

It is a large order to discuss child-rearing patterns in relation to all normal tension outlets and to all extreme threats to mental health. Such considerations are complicated further by the fact that child-rearing patterns are not fixed but vary from one area to another, and from one period to another.

The revolution in child-care patterns in the last 15 years testifies to the fluidity of our culture, its capacity for change, and the opportunity both provide for influencing the culture if we can be sure of our ground in doing so. Difficulties in being sure come from disillusionments resulting from one-sided views of the effects that given patterns have on child development. The rigid routines of feeding, toileting, and sleeping, advocated in the thirties, grew out of an oversimplified concept of conditioning plus pediatric concepts that dealt with nutrition and physical hygiene generally without regard to the emotional consequences of the techniques of imposing these routines. During the forties, there was a tendency to go to the opposite extreme. Both excessive coercion and excessive indulgence brought problems for children.

There is no sure guarantee that we won't make just as many mistakes in the future. But the best insurance against that seems to lie in developing as comprehensive and balanced a picture as possible of the child's needs and of the relation of the culture

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Based on a paper presented at the 1956 Forum of the National Conference of Social Work.

both to these needs and to the child's ability to satisfy them. It has taken dramatic and painful experience to force our attention to some of the most obvious interactions of culture and child needs. For instance, the studies[2] of Anna Freud, Bowlby, and Spitz are significant in relation to children's problems of separation not only in wartime but also in our peacetime patterns of babysitting, hospitalization, and frequent moving, which uproots little children from the home, neighborhood, and friends with whom they have tried to establish firm relationships.

Several absorbing new books[3] show us in very different ways how complex these interactions are and how many factors both in the culture and in the child are involved in thinking about child-rearing practices. To these I would add various significant studies[4] of factors involved in the development of anxiety and breakdown in reaction to stress in childhood.

A Complex Phenomenon

All these studies make clear that mental health is always mental health in *a given setting* with each setting's special demands, resources, stresses, and rewards. Mental health is also relative to the *kind of person* we are dealing with; there is no one standard of mental health for everyone. It is also relative to our *concept* of mental health. Children of head-hunters learn ways of using their aggressive drives that are consistent with good mental hygiene in their culture but not in ours. Our child-rearing patterns and concepts of mental health have to be looked at in relation to the culture as a whole—its values, acceptable goals, and the things it disapproves or won't stand for.

Child rearing includes all the cultural influences within and without the family that condition and canalize the child's energies—emotional, motor, intellectual, and so on. Physiological levels of conditioning by feeding and toilet-training experiences are among the first and are very important, but they become interwoven with, offset by, and overlaid by many other levels which are influenced not just by the mother, or even by the family as a whole, but by the whole neighborhood and larger culture as it impinges on the child. For example, one child we studied was quite free from early toilet-training pressure, but when the family moved into a new neighborhood the other children and parents laughed at her because, at 2, she was still wearing diapers. At the Sarah Lawrence College Nursery School in the late thirties and early forties, there were many children whose mothers began toilet training "too early" but who were still happy children, doubtless because they were enjoyed, cared for tenderly, and loved.

In addition to watching the family and the culture as a whole, we need to give separate consideration to the positive and negative aspects of the problem: building mental health and preventing mental breakdown, as well as the remedial approaches needed to handle breakdown when it occurs. Building mental health is a matter of building areas of satisfying life in warm relationships with people, and in work and play[5] and in *building ways of solving inner and outer problems*. Preventing mental breakdown is a matter of preventing cultural stress beyond the point that can be handled by individuals, and along with this, *increasing the individual's capacity to cope with stress*. Remedial approaches use both positive rebuilding and preventive, or stress-reducing, techniques.

Building positive strength involves a series of stages or steps which we need to clarify before we talk concretely about child-rearing patterns in the culture—steps partly formulated by Erikson in *Childhood and Society:*[6]

1. Finding that life is good and that needs can be met: *trust*.

2. Finding that you can meet them yourself: *autonomy*, *initiative*, and *industry*.

3. Finding that you can work with others toward meeting group needs: *cooperation*.

4. Finding that threats and danger can be handled, through *avoidance* or *mastery*.

Cultural Influences

We must look at cultural and child-rearing patterns as they affect the needs of the child at each age-level—infancy, preschool, school-age, adolescence—and his ability progressively to tolerate and cope with stress. A balanced approach also involves thinking about "emotional needs" and "ego development," and their integration both as positive interests and areas of satisfaction, and as methods of control and defense. In our thinking, then, about child-rearing patterns and the impacts of the culture on them we will want to keep in mind these questions: What does this pattern or group of patterns mean to the child emotionally? What do they mean to the development of his skill in handling the environment? What do they mean for his image of himself and of the world in which he lives?

Among the many obvious aspects of the culture affecting children in the United States are:

1. The small family with its individualistic and competive, but cooperative, values; its areas of spontaneity and rigidity; its mobility; its reliance on babysitters; its excitement about, but often sense of being burdened by, the babies;

2. Medical guidance, which dominates hygiene, feeding-elimination-sleep routines, inoculations, vitamins, separation of mother from the child immediately after birth and during hospitalization;

3. Property with its competitive values and its stimulus to interference with the freedom of the child; its comforts, play resources, creative stimulus;

4. The culturally heterogeneous and conflictful life of many communities—religiously, morally, sexually, aggressively, and structurally—in relationships between classes and shifts from one class to another;

5. Educational ambition which includes the requirement to meet standards of performance in every area, as well as to develop an understanding of oneself and the world one lives in;

6. Measurement consciousness, with its stimulus to growth and also to standardization of the child by pressure to conform to norms which generally ignore or minimize the wide range of individual differences in normal samples;

7. Confusion regarding discipline, values, and demands made on the child;

8. Mobility: the frequency of moving which can increase confusion in values, make it hard for the child to sink in roots and develop a sense of stable harmony between his inner self and a familiar world outside; which at the same time may acquaint the child with a wider range of people and communities, and lead to broader awareness of ways of life;

9. Distorted or deprived parent-child relations growing out of the deprivations of the previous generation, in which the cumulative effects of two world wars are exacting an increasing toll; parents' compensatory efforts to create happy experiences;

10. The increasing dominance of irreality and secondhand experience as TV, added to movies and radio, becomes an easy pacifier for children from the age of 2 on, along with the increased information that TV brings to children.

These influences do not come one by one but are fused in the experience of the baby who is greeted with enthusiasm and cared for thoughtfully. A typical middle-class suburban or metropolitan child is born in a hospital, fed from a bottle and often with a bottleholder as soon as he is steady enough to get his milk that way. He is brought up in a buggy, crib, high chair, playpen, and other furniture. He may be toilet trained early or late, but the chances are that his mother hates diapers. Babysitters substitute for mother when she goes shopping. Muscles and large-muscle activity are encouraged from his earliest months by both his parents, who get excited as he learns to sit up, stand, walk, and climb. Yet as he begins to get into, onto, and under furniture and to grab it, he is generally interrupted, scolded, or slapped for the exercise of the very functions his parents stimulated. Father's professional training may make him quite preoccupied in getting his M. D. or Ph. D., or getting "ahead," and leave him with little chance to play. Probably our typical child's mother doesn't sing him any lullaby, but he does see television early. If his father is in the Army or Navy or is with a big corporation that manufactures and sells on a national scale, his family may move from one place to another too frequently for him to establish roots anywhere.

Stress Producing Factors

These things all sound familiar enough and certainly in and of themselves are not likely to create pathology. We all know plenty of children who get along all right in exactly this kind of life, especially when parents feel comfortable with their own design for living and can give the growing child the support he needs at crisis points or transition points. When does trouble arise? What do these things have to do with hyperactivity, nervous habits, autism, psychogenic retardation, phobias, uncontrollable aggression and other problems brought to our clinics?

We are far from having the necessary data for dealing with such troubles empirically. As professional people we have tended to focus on a few central areas: feeding and toilet-training experiences; discipline; separation from mother; frustrations in the mother-child relation as a whole. But many other factors are involved, most of which have not been studied fully.

We agree that mental health suffers from:

1. *Vulnerability:* exposure to excessive stress;

2. *Emotional deprivation*, traceable to one or more of several sources, and including lack of adequate range of *gratification;*

3. *Anxiety*, also traceable to any combination of a multitude of sources;

4. *Conflict:* lack of integration; and

5. *Lack of adequate defense* against, and compensation for, stress and deprivation.

When factors such as those just mentioned produce anxiety, conflict, or insufficient gratification, particularly in a child who is at a sensitive stage of development or who is naturally vulnerable, we have trouble. The same combination of conditions can be disturbing to one child but not disruptive to another.

Vulnerability in the child may arise from unusual sensitivities, uneven growth patterns, specific damage—as a brain damage, illness, or other cause. Vulnerable children make mothers anxious, and this anxiety contagiously makes the children more anxious, lowering their thresholds for response to stress. Children with more than usual sensitivity to sounds or sights or to sensory stimuli in all modalities are more exposed to all the minor and major impacts of the environment.

In our culture, the sensitivity of parents to the normal, or rather to the optional and ideal, often makes them tense, or even guilty, at any deviations or failures to reach the ideal. Thus, in a norm-sensitive culture, vulnerability easily creates a cycle of mutually reinforcing anxiety. Such parents need help in developing more tolerance for deviations from the ideal all along the line.

With babies who have severe colic, diarrhea, and other physiological misery in their first 3 to 6 months there is, in addition to the anxiety of the mother, her fatigue, even exhaustion, which in our small-family culture means that the baby is cared for by a mother who hasn't the strength constantly to give such a baby the extra supply he needs to help the process of establishing inner stability.

Emotional deprivation both makes a baby vulnerable, and, as in the types of depressed and anaclitic reactions described by René Spitz, interferes with basic growth drive. This emotional deprivation occurs also in a cultural setting where a mother may have to go to a hospital for a period of time and can leave no familiar mother-substitute with her baby.

Mechanical feeding devices, mechanical nursemaids, like playpens, the culture pattern of isolating the baby from birth, all can contribute to emotional deprivation when they are used to excess or without awareness of what the experience means to the baby. We know from animal studies that deprivation of sensory experience interferes with the development of intelligence, and observations of young children give plenty of evidence that they use sensory or other basic gratifications to offset frustrations and disturbed feelings. Isolating devices, like playpens, can in effect reduce needed sensory gratification and comfort.

Cultural factors which interfere with a rich infantile sensory experience can be expected to leave the child without reserves in his mental-health bank to balance up the withdrawals by deprivation and trauma. Such factors include all the conditions in middle-class life which oversanitize, overorganize, overstructure the life of the young child so that he is unable to obtain the natural primitive gratifications which build this balance in the emotional bank—from mud pies to war whoops.

Anxiety may be generated by many factors. Some major ones are these:

— irregularities in the child's growth pattern, such as in children who are verbally advanced but slow in motor development, or the reverse, in a subculture which emphasizes the importance of meeting standards or normality in a family that expects the child to meet high standards in every area.

— difficulties in coordination which produce frustrations to the child attempting to master his environment;

— blocks, interruptions, and frustrations in exercising autonomy at the age when he has his autonomy spurt; interferences which are an everyday matter in the city where middle-class children are often harnessed, held by the hand, and hovered over until kindergarten age or later;

— traumata from operations, accidents, and such, particularly when these occur before the age of 3, and in quick sequence, or at a time when the child is making other difficult adjustments;

— autonomic instability, aggravated by overstimulation, illness, or emotional stress;

— physiological pressures, due to problems in feeding, tense toilet training, skin or temperature sensitivities, and such;

— inadequacy in coping with physical threats from peers or adults, due to low muscle tonus, small size in relation to the rest of the family;

— sudden disturbances in established relationships, due to illness in a parent, conflict between parents, or long absences.

All of these factors need to be seen from a cultural or child-rearing point of view in relation both to adult attitudes and handling of the child, and to the concrete experience of the child in the environment.

Normative pressures in our culture add to the anxiety around growth irregularities ("my 15-month-old boy is walking but he isn't talking yet"). Property emphases in our culture that lead to constant protection of things from the child ("nothing is safe in our house") involve frequent interruption of the child's drive to be active and explore which creates anger between mother and child. Cultural patterns of doing things *to* the child (inoculations, operations, and other body violations) at an age when the child is old enough to suffer and remember but not old enough to understand or master the threat also cause anxiety in children, especially those under 4 or 5. Cultural anxiety about nutrition, quantity of food intake ("why doesn't he finish that bottle?"), and about elimination ("he didn't have a bowel movement today") contributes to physiological tension and uneasiness about eating and related basic functions. At a later age, grossly contrasting patterns of approval and disapproval in different social classes can create anxious conflicts: to fight, in the lower-class groups studied by Havighurst and Davis [7] or not to fight, in middle-class groups.

In the heterogeneous culture of large cities, it is the rule rather than the exception for the child to be exposed to widely differing values and standards in the home and neighborhood. "What mother forbids, the mother next door permits," and vice versa, "Grown-ups don't do what they preach. Public leaders tolerate gangsters or connive with them." "Families expect one standard; schools expect a different one; schools try to adapt learning demands to the child's growth rate, while parents want the child to learn to read at 6," or vice versa. Many strands of influence are tying each other into knots with the child in the middle.

Conflict and lack of integration also arise from deeper sources. With the high divorce rate and the prevalence of home tension, from early months the child may have conflicting identifications; that is, conflicts in identifying with two people who can't achieve integration in their mutual life. Oedipal conflicts and sibling rivalries are often increased by the intensity of emotional relationships in a small family, made smaller by the mobility of American life which separates children from potentially comforting grandparents.

For comparison, we might look at a village child in India whose mother has an easy experience at childbirth, nurses her baby until he is 2 or more and old enough to lose interest in nursing because of the competition of other activities, carries him with her wherever she goes so that he does not know what separation is. Her child is carried by an older sibling when a new baby takes over his mother's arms. He receives no toilet training until he is old enough to get around on his own feet and learns where to go. When he begins to run around for himself, he has the freedom of the house and the village with nothing to daunt or disturb his budding autonomy since there is nothing breakable or damageable. With many of these children no severe separation, isolation, or deprivation is experienced.

We can see that we have here a rich complex of factors among which the specific feeding and toilet-training experiences are only two, however fundamental they are, because of the opportunity for massive emotional reactions and conditionings in these settings.

Defenses against stress and deprivation have already been mentioned in relation to emotional deprivation, but more is needed here. Everything in the subculture, including the neighborhood as well as the family, which builds confidence, pride, skills in mastery, security in problem solving, flexibility, and perspective on emotional disturbance—including such expectations as are implied in cliches like "every cloud has a silver lining" or "tomorrow will be another day" (as contrasted with "it never rains but it pours")—is part of the total child-rearing experience and contributes to the child's equipment to deal with the stresses of his life.[8]

With the opportunities provided by the subculture for the optimal development of the resources of the individual, we can also include intelligence. Children in slum areas, bad schools, deprived neighborhoods, may or may not be deprived of the emotional nourishment they need, but they are likely to be deprived of the experience of seeing how people cope with problems. They may thus be left more helpless than middle-class children who can observe and participate in a wider range of learning experiences that are useful in coping with emotional and environmental problems. The more our schools can provide genuine experiences in real-life situations, the more confidence children can develop in their ability to handle problems.

Dr. Margaret Fries in this country, Dr. D. R. MacCalman reporting on British children, and Rhoda Metraux reporting on German child-rearing patterns [9] have, in different ways, emphasized the importance of learning to cope with frustration or life's problems as such—an approach quite distinct from that of measuring up to norms for "successful performance" in all areas. Learning to stand up for oneself, to think for oneself, to find solutions of one's own, are very important ingredients of coping.

Roger Barker's research[10] on a small rural town in the middle west, where delinquency is unknown and children are by and large relaxed and healthy, records a comfortable tempo, much time for exploring and mastering one's environment, much companionship between adults and children, and warm support and encouragement when a child fails in some effort like learning to fly-cast.

Strength Building Factors

Mental health develops when most of the following are present:

(a) *Good start physiologically*—freedom from gastrointestinal discomfort, frustrating defects in coordination, perception, integration;

(b) *Emotional nourishment;*

(c) *Adequacy of sensory stimuli;*

(d) *Opportunity for motor development* and freedom from excessive pressure for performance;

(e) *Range of experience;*

(f) *Stable relations with mother* during the period of establishing clear concepts of self and other persons;

(g) *Stable, respected interests, possessions* (cathexis);

(h) *Opportunity to exercise autonomy*, initiative, industry, to achieve mastery over various areas of the environment;

(i) *Feeling supported*, accepted, a source of pride and satisfaction to parents;

(j) *Opportunity to cope* with gradual doses of frustration and difficulty;

(k) *Participation in group life* with some recognizably consistent pattern (freedom from demoralizing value conflicts).

To Summarize

The complexity, conflict of values, pressure to perform, and emphasis on protection of property make it impossible to give any simple answers to the question of what is the effect of child-rearing patterns on mental health today. Mental health for a lifetime cannot be guaranteed by self-demand feeding in the first year of life, nor does mental breakdown inevitably occur as a result of early toilet training. Children who are shy at the age of 4 are not necessarily on the way to schizophrenia. It becomes more and more clear that mental health and mental disturbance are the resultants of a complex and varied group of influences from within and without the individual child, and that the part of wisdom is to become increasingly aware of what this total interplay actually is in the case of individual children. This means thinking of the equipment of the individual child and what his resources are for coping with the pressures of his situation, as well as thinking of what those pressures are as he experiences them. One child thrives on a routine which cramps the style of the next. One child goes haywire with a degree of freedom which another child uses creatively.

This brings us to the concluding question: What child-rearing help does each individual child need in order to build more strength to handle the problems he finds in his own subculture situation?

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An ancient enemy of dental health gives way to controlled fluoridation

PROPHYLACTIC AGAINST CARIES

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THE YEAR 1955 marked the tenth anniversary of several public-health studies testing whether dental caries was a disease amenable to control by a community-wide prophylactic measure. This article concerns itself with just one of those studies—the Newburgh-Kingston Caries-Fluoride Study—which had its start on May 2, 1945.

Dental caries has long been recognized as an ailment of mankind. Archeological studies indicate that even as far back as the Danish Stone Age, human beings have suffered the pangs of tooth decay. The most ancient of all known works on medicine, the papyrus of Ebers, written about 37 centuries B. C., mentions dental diseases and therapeutic measures for their control.

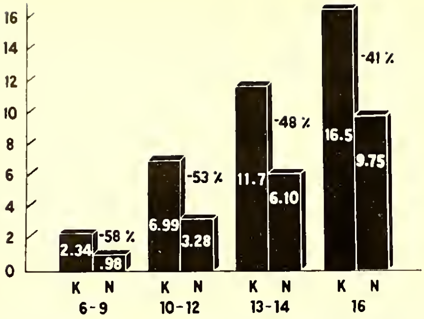
In more recent times the writings of contemporary authors have added much to our knowledge concerning this distressing problem. Studies made on children of preschool age, on school children, and on adolescents and adults[1] have shown evidence that dental disease is practically a universal problem, starting in early childhood and continuing throughout life. The most striking data concerning accumulated effects of dental disease were collected in 1941 during the physical examinations of inductees called up for Selective Service in the Armed Forces of the United States. Out of some 2,000,000 men examined, 900,000 were rejected for physical and mental disabilities. The leading cause for rejection among the 900,000 concerned dental defects.[2]

Such data emphasize the fact that dental diseases are a public-health problem of great magnitude. And such data also serve as the epidemiological basis for investigation of the problems and methods for their control.

The historical background for fluoridation as a public-health measure to control dental caries dates back to the observations made on another dental disease, mottled enamel.[3] The low incidence of dental caries among persons exhibiting such mottled enamel had been reported long before it was known that fluoride was the agent responsible for the mottling.[4] In the United States these observations were made primarily among the inhabitants of the Midwestern and Western States where such mottling was endemic in nature.

The etiology of mottled enamel was not determined until 1931, when three independent studies demonstrated that fluoride in drinking water was the causative agent.[5] Following this, a series of epidemiological studies, conducted by the Public Health Service of the Department of Health, Education, and Welfare, correlated the incidence of mottled enamel and dental caries with the fluoride content of the drinking water.[6] The evidence strongly indicated there was less dental caries in areas of endemic dental fluorosis, where fluoride was found in the drinking water. Further studies in 1941 and 1942 suggested that in regions where the fluoride ion concentration in drinking water was approximately 1 p. p. m. (one part per million), there was about 60 percent less dental caries than in regions where the fluoride ion was well below this concentration, or absent from the water supply. Also, this reduction was achieved without the endemic occurrence of disfiguring mottled enamel.[7]

On the basis of these investigations, it was suggested that if fluoride-deficient water supplies were supplemented up to an optimum concentration of approximately 1 ppm. F, this procedure could effect a



Rate of decayed, missing and filled teeth per child aged 6–16 in Newburgh and Kingston, N. Y., 1954–1955, ten years after the beginning of water fluoridation in Newburgh.

comparable result in diminishing dental caries.[8] Now, for the first time in history, a public-health method seemed to be available to combat dental caries. While the exact manner in which fluoride acts to prevent decay is unknown, it is now thought that the fluoride ion is incorporated into the structure of tooth enamel and renders it more resistant to acid decomposition.

Between 1944 and 1947 a number of studies were initiated in the United States and Canada to determine the practical application of supplementing communal water supplies with fluoride compounds as a public-health measure to reduce dental decay.

In December 1942 a long-range caries-fluoride study plan was brought before the New York State Department of Health for consideration. It was favorably received, and in March 1944, a Technical Advisory Committee on Fluoridation of Water Supplies was appointed to study the proposal. This committee, composed of leading medical, dental, biochemical, and biostatistical authorities, was requested to recommend the types of medical and dental examinations which it felt would be necessary to determine the safety and effectiveness of water fluoridation.

The New York State Department of Health also explored the selection of communities suitable for such a study. The cities of Newburgh and Kingston, situated about 35 miles apart on the west bank of the Hudson River, were well suited for a project of this sort. Each had a population of approximately 30,000. They were also comparable in almost all the essential factors required for the study. These factors included: (1) fluoride-deficient water supplies, (2) composition of population in regard to size, age, sex, color, nativity, economic status, (3) geography and climate, (4) socio-economic conditions, and (5) past dental experience. The proposed study plan was discussed with the local health officers, physicians, dentists, voluntary health agencies, and civic officials. Through the foresight and progressive public-health viewpoints of these citizens, both cities agreed to cooperate with the Department of Health. The Newburgh City Council, acting as the Board of Health, unanimously approved the fluoride supplementation of their city water supply. Kingston agreed to keep its water fluoride deficient and the city would thus serve as the control area.

On April 24, 1944 the Technical Advisory Committee on the Fluoridation of Water Supplies again met with members of the Health Department's staff. After a careful review of the literature and a discussion of the objectives of the study, the committee unanimously approved the proposed plan. Further, the committee agreed to help set up the types of examinations deemed necessary. It would also help determine the frequency at which these examinations should be made.

Preparations for Study

One of the questions which was raised during the early discussion of this study related to possible liability for damages on the part of either the city or State in the event anyone claimed ill effects from drinking fluoridated water. This question was addressed to the Attorney General of New York State on March 14, 1944; and on April 28, 1944, he replied, concluding his letter as follows:

"Liability of the State for negligence could arise from three circumstances: (1) if the State Department of Health were to recommend the introduction of fluorine in amount higher than scientific knowledge disclosed to be safe; (2) if the Department were to undertake the supervision of the introduction of the fluorine and in that respect fail to exercise care that only a safe quantity be used; and (3) if the Department failed to exercise care in guarding against the introduction of excessive amounts of fluorine in connection with its duties as to potable waters under article 5 of the public-health law.

"My answer to your inquiry is, therefore, that no negligence could be attributed to either the city or the State for the introduction of fluorine into a city water supply upon the recommendation of the Department of Health, if the amount of fluorine introduced is only such as has been found by scientific studies to be safe. The municipality would be liable for negligence if amounts were introduced, intentionally or through negligence, in excess of such as scientific knowledge discloses to be safe. The State might be liable in any of the three possible situations I have supposed."

In June 1944 dental and comprehensive medical examinations were conducted among the preschool and school-age children in the two cities. These examinations constituted the collection of the basic data necessary to evaluate the study.

Clinical Examinations

Clinical dental examinations were made for all of the elementary-grade school children aged 6 to 12 in both the public and parochial schools in Newburgh and Kingston. All the examinations were made by one staff dentist using the classic mouth mirror and sharp explorer technique. The examiner called off the defects as discovered and these were recorded by a clerk on a dental record card specifically designed for the study.

The findings for each tooth were indicated on the record card as—caries-free, pit or fissure (these were not counted as carious defects unless there was visual evidence of caries, or the explorer on pressure sank into soft tooth structure), frank caries (and here the involved tooth surface was noted), fillings present (with tooth surfaces noted), missing and unerupted teeth, and the presence of hypoplastic areas. A space was also provided for the notation of unusual findings. An analysis of these initial examinations demonstrated that the caries experience in the two cities was comparable.

Comprehensive medical examinations conducted as part of the Newburgh-Kingston study were recommended by the advisory committee. There was no reason to believe that the fluoride added to drinking water as a routine part of the water treatment process would act differently than the fluoride naturally present in water supplies. Nevertheless, it was considered desirable to test this remote possibility by periodic medical examinations of groups of children under carefully controlled conditions.

Initially a group of 500 children was chosen for study in each city. They ranged in age from newborns to 9-year-olds, with the sexes equally represented at each age as far as possible. As planned, groups of infants were added during the ensuing years. This procedure included in the study Newburgh children who had been exposed to fluoride at 1 ppm. during the entire period of their fetal development. A similar age group of children in Kingston served as controls.

An effort was made to select the children in proportion to the population in various parts of each city. Only those children were enrolled whose families were reasonably expected to remain in the city for the duration of the study. Attention was also paid to obtaining from each city a comparable selection of children according to socio-economic status. This was not entirely possible because of the voluntary nature of the examinations.

A research clinic team conducted the basic and followup medical examinations in both cities. The physical examinations were performed by a board-qualified pediatrician, who also directed the work of an experienced public-health nurse, a laboratory technician, and a clerk-receptionist.

A careful medical history was taken at the time of each child's initial visit to the research clinic. This history was supplemented at each annual visit. A physical examination was performed, with special emphasis placed upon tissues and organs which had been mentioned as possibly affected by fluoride. Thus, special attention was directed toward oiliness or dryness of the skin, skin turgor, and abnormal markings or brittleness of the nails. Physical measurements made at the visit consisted of weight, standing and sitting height, circumference of head, and circumference of chest.

Laboratory Examinations

The basic and followup laboratory examinations consisted of urine analysis, hemoglobin, total leucocyte count, and total erythrocyte count. Roentgen films were taken of the right wrist and both knees of each child. In the final series roentgen films of the lumbar spine were also taken. These films were read by a leading roentgenologist without his knowing from which city they came. Special attention was paid to any change in bone density in view of the known occurrence of osteosclerosis in chronic fluoride intoxication.

In addition special eye and ear examinations were made of groups of Newburgh children after fluoridation started. Children of various ages were selected from those enrolled at the pediatric research clinic. These children were given special opthalmological examinations, which included the mapping of visual fields and a determination of transparency of cornea and lens. The same group received special otological examinations, including audiometric tests. The findings on both these special examinations fell well within the limits expected of any normal group of children of these ages.

The community water supplies at the time of the basic examinations were both fluoride deficient. Newburgh's water contained 0.12 ppm. F, and Kingston's water contained 0.05 ppm. F. On May 2, 1945, Newburgh's water supply was supplemented with sodium fluoride to bring its fluoride ion concentration up to 1.0 to 1.2 ppm. This concentration has been continuously maintained without difficulty since that date. Kingston's water supply has remained fluoride deficient.

During the same year, 1945, Grand Rapids, Mich., and Brantford, Ontario, also embarked upon long-range water fluoridation studies. The final reports of these two gratifying studies have been published elsewhere.

When in March 1944 the Newburgh City Council approved the water fluoridation program for its city, the local newspaper publicized the project. It was not until May 2, 1945, however, that the water supply was supplemented with sodium fluoride. During this interim the local health officer received numerous complaints from outraged citizens. The most common complaint was of digestive disturbances. Some persons said that the fluoridated water was discoloring their saucepans. One woman complained to her dentist that the "fluoride water" had caused her denture to crack. These incidents all occurred before supplemental fluoride was actually added to the water supply. Sometime after May 2, 1945, the local newspaper published an editorial which pointed out to the people of Newburgh how some citizens can imagine all sorts of disabilities from nonexistent causes. That put an end to the complaints.

Ten Years of Fluoride

The 10 years that followed the fluoridation of Newburgh's water supply were indeed interesting to science. Annual clinical dental examinations were made of the Newburgh children each of the years 1944–45 through 1954–55. In Kingston the children received these same examinations from 1945–46 through 1954–55. In addition to the clinical examinations, dental roentgenograms were included in the examinations for the years 1949–50, 1953–54, and 1954–55.

Progress reports were published after 3, 4, 6, and 8 years of fluoride experience in Newburgh. All the reports showed a continuing downward trend in caries experience among the children in the fluoridated city. In Kingston the caries experience remained relatively unchanged.

While the dental examinations were presenting hopeful data, the annual medical examinations of the Newburgh children were also encouraging. No untoward reactions to the ingestion of fluoridated water had been observed. In additon, other workers conducting scientific research projects concerning fluoride metabolism added to the weight of evidence concerning the safety of ingested water fluorides.[9]

On the basis of five years of research in Newburgh and Kingston, and in view of all the favorable reports dealing with ingested water fluorides, the New York State Department of Health issued a statement of policy on January 2, 1951, concerning water fluoridation as a public-health measure. The Department recommended that all communities in the State which could fluoridate their water supplies under adequate control measures should do so. At the same time specific criteria were prepared for the guidance of local health officials and water engineers relative to the installation of fluoride-dispensing equipment, the laboratory tests which would be required to assure the desirable fluoride ion content, and the duties of the operator of a water-treatment plant actively engaged in water-fluoridation operations.

In June 1955, after 10 years of fluoride experience, medical and dental examinations were completed in Newburgh and Kingston.[10] The results of these examinations were worth all the years of trial. They reaffirmed what had already been demonstrated in the early epidemiological studies. The children in Newburgh aged 6–9, who had ingested fluoridated water throughout their lives, enjoyed a 58 percent reduction in dental-caries experience. Even those children who had not had the full benefit of fluoridated water throughout the period of tooth formation exhibited a reduction in tooth decay. The reduction in this group of children, aged 10–16, ranged from 53 percent to 41 percent less dental-caries experience. The percentage differences depended upon the age at which the child started to ingest the waterborne fluoride.

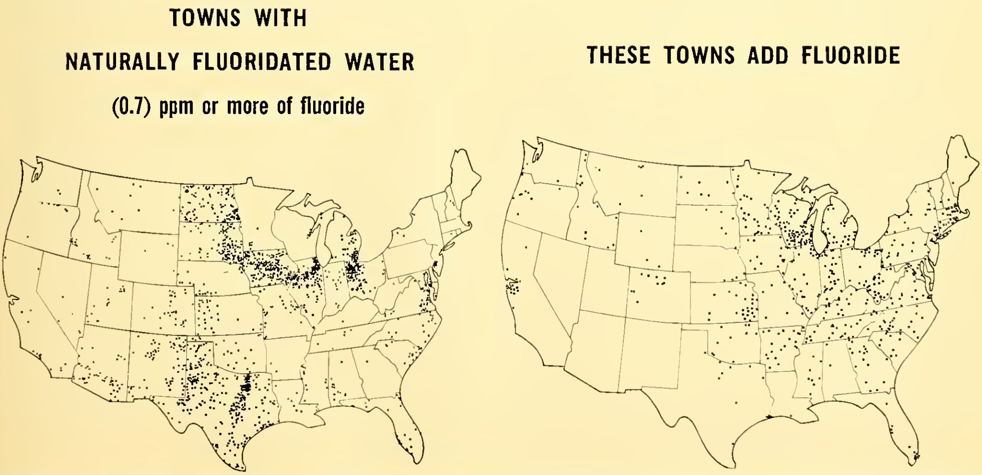
Throughout the dental examinations, a good deal of attention was paid to the condition of the first permanent molar. This tooth erupts in a child's mouth at about age 6, and succumbs to caries at an early age. It was significant therefore to find that the children in Newburgh showed a considerably lower dental-caries experience for this tooth than did Kingston children. Of even greater significance, perhaps, was the fact that Newburgh children lost fewer first molars to the ravages of decay. The loss rate for Kingston children was 8 times greater than that for the Newburgh children aged 6–9.

An additional fact was also brought to light. The study showed that children in the city with fluoridated water had considerably less untreated caries than did children in the control city. Since it had previously been determined that the amount of dental corrective services in both cities was comparable, it was reasonable to deduce that the effectiveness of caries prophylaxis through water fluoridation reduced the magnitude of the dental-caries problem to a point where the active complement of dentists could better control such caries as did occur.

As previously mentioned, the final dental examinations included roentgenograms in addition to the clinical mirror and explorer survey. The results of these 2 techniques showed that among the children in Newburgh, ingested water fluorides imparted a selective protection to the proximal (adjacent) surfaces of their teeth. The number of carious proximal surfaces among the Kingston children was three times greater than among Newburgh children. This is highly important since proximal caries presents difficulties in both detection and correction. Frequently the correction of such decay is costly in terms of sound tooth structure which must be removed for placement of an adequate filling. It is also costly from a financial viewpoint. Thus children in fluoridated Newburgh benefited both qualitatively and quantitatively in terms of dental-caries prophylaxis.

The early epidemiological studies of endemic dental fluorosis had demonstrated that there was no danger of disfiguring mottled enamel at the level of about 1.0 ppm. F. It was important therefore to determine whether the children in Newburgh exhibited any signs of this condition after 10 years of fluoride experience.

Unfortunately, the term mottled enamel is applied to all degrees of dental fluorosis. Actually, dental fluorosis exhibits itself in various degrees. These cover a spectrum ranging through questionable, very mild, mild, moderate, and severe, depending upon the amount of fluoride which has been ingested. The questionable and very mild forms are identified by the appearance of almost indistinguishable white flecks most frequently seen on the cusps of some of the posterior teeth. These present no esthetic problem nor does this form of fluorosis affect the health of the teeth. The moderate and severe forms of fluorosis appear as brown to black stained areas especially visible on the anterior teeth.



TOWNS WITH NATURALLY FLUORIDATED WATER (0.7) ppm or more of fluoride

THESE TOWNS ADD FLUORIDE

The chances are that people in even more towns and cities than are indicated on these maps are drinking water containing at least 0.7 part per million of fluoride, for some places with naturally fluoridated supplies may not have reported.

This stain may be accompanied by pitting of the enamel when the fluorosis is of very severe degree.

The examinations for dental fluorosis, or mottled enamel, were conducted in Newburgh by an investigator with long experience in the detection of the earliest of such lesions. Examination was also made for enamel opacities due to causes other than ingested fluorides. The results of these examinations were most gratifying. Among the children examined in Newburgh no cases of moderate or severe mottling were observed. The examination made for nonfluoride enamel opacities revealed that Kingston children displayed many more of these than did children in Newburgh. This seems to confirm the report of another investigator, that ingested water fluorides at the level of 1 ppm. appear to reduce the occurrence of idiopathic (nonfluoride) white spots on the teeth.[11]

During the 10-year span of study, the medical examinations were conducted as planned. At the end of the study period, the total number of children who had been examined in Newburgh amounted to 817. In Kingston 711 children had been under observation.

Medical Results

The results of the 10-year medical observations revealed that there was no significant difference in the findings on physical examination between the Newburgh and Kingston children. Neither did the roentgenographic films, blood picture, urine analysis, nor special opthalmological and otological examinations show any significant deviation from what is normally expected in children of the ages observed.

Further, a comparison was made of the stillbirth and maternal and infant mortality rates in Newburgh and Kingston for a period starting 5 years before the initiation of fluoridation and during the 10 years of the study. The relatively small numbers involved gave rise to considerable variation in the annual mortality rates. However, the long-term downward trends were similar in the two cities and there was no detectable change in the trend in Newburgh after fluoridation.

The crude death rates from cancer and cardiovascular-renal disease in Newburgh and Kingston from 1942 through 1954 showed no consistent pattern from year to year. However, it is clear that there has not been any increase in deaths from these causes in Newburgh as compared with Kingston during the period of water fluoridation.

Lastly, all the laboratory reports dealing with work on fluoride metabolism have given indication of a most significant fact, namely, drinking fluoridated water at the recommended concentration is safe.

The Newburgh-Kingston Caries-Fluoride Study represents a striking example of applied research in public health. The results of this study, taken together with the results of comparable long-range studies, demonstrate beyond question the effectiveness and safety of water fluoridation as a public-health procedure.

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PREVENTIVE MENTAL-HEALTH SERVICES IN PUBLIC HEALTH

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COMMUNITY mental-health programs of various kinds, focusing on numerous problems, utilizing a range of methods, and under varying sponsors, are developing in many areas throughout the country. Although there is agreement as to the need for such programs, there is not apparent any definitive set of program policies and procedures to guide their development, which was stimulated greatly by the passage of the National Mental Health Act in 1948. This paper reviews the background and experience of the St. Louis County Health Department's Mental Health Service, begun in 1951.

It is well known that clinic and hospital facilities are insufficient to meet the problems of mental and emotional illness in children and adults. Most hospitals are overcrowded and most clinics have waiting lists. There are approximately 250 child-guidance clinics in the entire country and even these few are staffed with insufficient trained personnel. Requests for service far exceed the resources available to treat individual cases. Individual treatment of cases is expensive, and such clinical service inevitably can serve only a small percentage of the population in need of help. For these reasons a major focus of the St. Louis County Health Department's program has been directed to "preventive services" of education and early detection.

Although there is still much to learn about the causes of emotional and mental illness, it is generally accepted that much of the problem of adult maladjustment is related to experiences in childhood. The attitudes and behavior of parents toward children and stresses in parent-child relationships affect child and adult adjustment. Accordingly, programs which seek to deal with first evidences of behavior deviation in children and to provide a positive educational program to parent and school groups for "normal" children and families are developing.

A major stimulus to the establishment of the St. Louis County program was the interest and support of local welfare agencies, which for many years had recognized the need for mental-health services. Psychiatric services for children were entirely inadequate in the St. Louis metropolitan area. There was, for example, no child-guidance clinic in St. Louis County.

At the outset, two major service programs were incorporated in the new Mental Health Service Division: the child-guidance clinic, and the school mental-health service. These will be described in more detail below, but first we will review some of the concepts which influenced the decision as to the type of program to establish.

Generally speaking, the aims of mental-health services are, first, to assist a community in identifying its mental-health needs and to develop the most appropriate resources to meet them; and second, to gain greater understanding of the causes of mental and emotional disturbances, both from an individual and community point of view. As Lemkau has stated, there are two major areas in the field of mental hygiene: the preventive area and the therapeutic area—or "primary prevention" and "secondary prevention." [1]

The Mental Health Service of the St. Louis County Health Department is, to a great extent, based upon the concept of a system of classification of children's behavior problems according to degree of severity of these problems, and upon types of service designed to meet the various kinds of needs that children have.

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*With the assistance of the Mental Health Division staff and the cooperation of the administration and staffs of contracting schools.

Group 1 includes children who exhibit behavior deviations of a transient nature in reaction to environmental stress, or minor problems which are not severe enough to interrupt the usual processes of growth in personal and social maturation. Programs of mental-health education, such as those conducted by the Mental Health Association of St. Louis, to be mentioned later, are believed to be of value in helping parents understand their children's problems, and thereby help the children progress on the path of healthy personality development.

Group 2 includes children whose problems have persisted for a longer time, whose internal conflicts are manifested by anxieties that demonstrate a reduction of capacity to function adequately, whose disturbances threaten to disrupt their school and social lives, and whose problems become evident to teachers and other school personnel. In a medical sense these problems may be considered subclinical. The program of group therapy with mothers, as developed experimentally in the St. Louis City Schools and the school mental-health service of the health department and as described below, was an attempt to deal primarily with this group of children.

Group 3 includes children who are considered clinically disturbed. These children have more severe neurotic conflicts as shown in behavior of an aggressive or withdrawn nature that threatens to disrupt to a disabling degree their functioning in the home, school, and community. The child-guidance clinic, with its individual therapy with the child and his parents, is designed to serve children in this group.

Group 4 includes children whose emotional disturbances are of such a severe degree they are unable to function in the community, whose personality disorganization is such they are unable to adjust to life situations, and who are considered to be psychotic or pre-psychotic children. Treatment of such children requires residential treatment.

These categories, though seemingly arbitrary, are considered primarily for purposes of diagnostic evaluation, and for determining the most appropriate kinds of service to be developed in a comprehensive community mental-health-service program.

At the present time the mental-health service of the health department is attempting to provide a service to the community for children in groups 2 and 3, and cooperates with other community agencies in the development of services for children in groups 1 and 4. In St. Louis County, as is true in most communities, the resources for children in group 4 are extremely limited. The child guidance clinic assists in treating such children in some instances while they are awaiting placement. At present St. Louis County has no institution for residential treatment.

Clinic Service

The child guidance clinic, the first in the county, was established in the health department to provide diagnostic and treatment service for emotionally disturbed children in St. Louis County and for their parents who are unable to pay for private psychiatric care. This was a limited but much needed service to schools, social agencies, juvenile court, physicians, clergymen, and other citizens. The traditional clinical team of psychiatrist, clinical psychologist, and psychiatric caseworker was employed.

Usual diagnostic and therapeutic procedures of child-guidance clinics have been followed. Children and their parents are treated by the psychiatrist or by the psychologist or the caseworker under psychiatric supervision, depending on the nature of the problem. A beginning attempt has been made to conduct group therapy with mothers of children in individual treatment.

As expected, soon after the child-guidance clinic opened its doors, requests for service became much greater than the limited number of staff could meet. This situation was further intensified by the beginning of the school-contract program in the fall of 1951. In the first 15 months of the clinic's operation there were some 150 applications for service. Approximately 100 children were accepted for diagnostic service and recommendations, and 21 of these were accepted for treatment. By the end of 1955, requests for service had more than doubled. During several months in the past year, intake had to be closed, except for emergencies and special referrals from the school program.

When the child-guidance clinic was begun, the staff consisted of one full-time psychiatric caseworker, one half-time psychologist, one part-time psychiatrist, 2 part-time psychiatric residents, and one office clerk. Since the start of the school program, each of the 3 workers in that program have also been working part time in the clinic.

The county council authorized in 1956 an expansion of staff for the Mental Health Service Division to serve the clinic, the school program, and any allied programs that develop. When complete, the division's staff will include the following: a director, who is a psychiatric social worker, full time; a supervising psychiatrist, part time; 3 psychiatrists, part time; 1 psychiatric resident, full time; a chief psychologist, part time; 2 clinical psychologists and a psychology intern, all full time; a chief and 7 psychiatric social workers, all full time; and 3 clerk stenographers, full time.

In January 1956, the child-guidance clinic established a special service for the Juvenile Court of St. Louis County which heretofore had no psychiatric service regularly available. Previously the juvenile court had referred about six children a year to the health department. Present plans include collaborative work with the probation staff for screening and selection of youngsters for referral, diagnostic evaluation prior to court hearings so that recommendations may be made to the juvenile court, and limited treatment for a selected few.

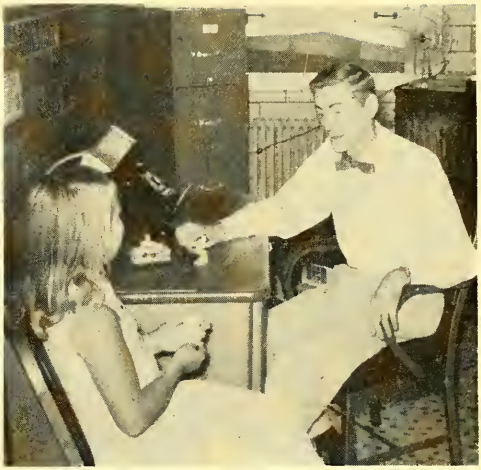
Different communities have different mental-health facilities for juvenile-court work. Some are administratively a part of the court staff[2]; others are separate from the court. It is believed that a service provided by the health department cooperatively with the court is desirable in that it emphasizes the health aspects of the work, and clearly leaves the legal responsibilities with the court. Evaluation of the St. Louis plan as it progresses is very necessary.

A fee schedule was put into effect in the clinic in January 1956, not as a source of revenue—since the clinic is tax supported—but for its therapeutic value. When people feel they are investing in the service they receive, treatment sometimes proves more beneficial. Many people in the past have wanted to pay, and have been embarrassed when not permitted to. On the other hand, a sliding-scale fee, based on ability to pay, does not prohibit people of low income from making use of the clinic.

The child-guidance clinic, with its multiprofessional staff to provide a clinical diagnostic service, treatment facilities for children and their parents who have problems of group 3 severity, and consultation service, is of great value as an integral unit of the Mental Health Service.

School Services

The School Mental Health Service program of the health department had its origin in a previous 4-year experimental project of group therapy with mothers of children with behavior problems who attended the St. Louis public schools.[3, 4, 5] This project, sponsored and financed by a local private organization, was carried on in six elementary schools from 1947 to 1951. An experiment in preventive mental health, the project used group therapy in working with parents, and had as its goal improving the behavior of selected children through modifying parental attitudes and the home environment.



Working within the St. Louis County mental health program a psychologist interviews a child referred from a school.

While evaluation of the project was considered to be valuable and necessary, funds for such intensive research were not available. However, expressions of teachers' and parents' opinions of a child's improvement were obtained through individual conferences. On this crude and subjective basis, approximately 80 percent of the children whose mothers participated in a therapy group showed some degree of improvement while the mother was in the group. There was no way of determining what other factors may have been operating to bring this about, or whether this improvement was sustained.

In addition to the school-centered group therapy program with selected mothers, a program of community mental-health education was begun by the same organization in 1950.[6] This program, also using group-discussion methods and audio-visual tools as springboards for discussion, is being carried on by the Mental Health Association of St. Louis.

Discussion leaders in this community program are lay volunteers who are trained, through the workshop method, by professional personnel in group discussion methods and leadership skills. Following training, the discussion leaders are on call to meet with PTA's, mothers' clubs, and other school, church, and community groups, to discuss the various normal problems of child development and parent-child relationships. Audiovisual tools, films, plays, and structured sociodramas, are used as foci around which discussion is centered. The discussion leader does not function as an expert or an authority. His role is to introduce the subject and the film (or other audiovisual tool to be used), to encourage and stimulate talk, to assist people to participate and express themselves, and to summarize briefly the various points covered in discussion. The raising of questions, sharing of ideas and experience, and shaping of opinions within a group are found effective in producing an active learning experience. Single group meetings are arranged with organizations, but on the recommendation of the Mental Health Association series of meetings are now the most common pattern.

The county health department cooperates with the Mental Health Association in the conduct of this program in several ways. St. Louis County schools with which the health department has a relationship are encouraged to make use of this program service in planning agenda with their PTA's and other parents' organizations. The psychiatric consultant, director of mental-health research, and director of the mental-health service of the Health Department function as consultants to the Association. They assist in the training of discussion leaders and in conducting basic and advanced training workshops.

Early Experiences

The school mental-health service of the county health department was begun in the fall term of 1951 in 3 of 32 county public-school districts. The first 3 districts were chosen because of the interest in and need for this kind of service expressed by the superintendents of the districts. Previously, these districts had contracted with the health department for other public-health services, including school nursing service. The mental health service was seen as an additional aid to these school communities. As the program developed, efforts were made to coordinate the services of the public health nurse and the mental-health counselor of the health department, in working with the public-school staff, to provide an overall health program in these schools.

Each school district contracted with the health department for its mental-health service, and paid a fee of 75 cents per child enrolled. This fee actually covered about one-third of the cost of the service. In 1954 the contract form was revised. Under the new provisions the school district pays the health department $5.50 per hour of service which makes the service virtually self-supporting. Six additional school districts have since contracted for the service. Two more districts have requested contracts to begin with the fall school term of 1956 if sufficient trained staff can be obtained.

Group therapy with mothers was chosen as its major method when the school program started because of the success of the experimental project mentioned earlier. A trained mental-health worker (psychiatric social worker or clinical psychologist) was assigned to each district part time, usually for 5 or 6 hours a week in an average-size school. At the outset, the program was staffed with these two workers and a director, each of whom gave half time to the school program and half time to the child-guidance clinic.

Many modifications from the city schools' project developed in the county program as time went on, and for a variety of reasons. A child-guidance clinic was now available as part of the county health department's service. Greater recognition was now given to developing cooperative work with the health department's nurses in the schools. More children were referred to other community agencies for planned followup. The service included secondary as well as elementary schools. More consultative work was done with teachers and other school personnel. Since the service was an experimental one, considerable flexibility in policies and procedures was necessary.

During the first year, 211 children were referred to the staff from the 3 original school districts. Two mothers' therapy groups were begun. The problems of most children were handled individually, through counseling with parents, teachers, and the children themselves, and by referral to other resources, including the child-guidance clinic.

Experience in succeeding years has indicated that mothers' therapy groups are more difficult to form in the county program than they had been in the city schools.[7] Between 1951 and 1955, mothers' therapy groups were organized and carried on in four schools.

Some of the county difficulties seemed to be related to the physical nature of suburban consolidated school districts; public transportation was difficult, and parents lived some distance from the schools their children attended. In some instances there seemed to be relatively little contact between the school and parents in the area. A good many schools referred problems which were not suitable for group therapy. Although there was readiness for individual counseling, especially in the upper socio-economic levels, there was some resistance to involvement in a group. At the same time school personnel were increasing their requests for other kinds of service, such as help to classroom teachers in dealing more effectively with problems in the classroom, and to students in the secondary schools.

Six Choices

In the past 5 years, numerous changes have occurred as the program has been adapted more closely to local school-district needs. From focusing primarily on the use of group therapy with selected mothers of elementary school children having behavior problems, the whole undertaking has broadened into preventive mental-health service.

Contracts now offer school administrators choices among six types of service which form the framework of the program:

1. Consultation service to assist school personnel and other responsible persons in the community in developing appropriate preventive mental-health programs to meet their needs;
2. Case finding, screening, and evaluation service to identify children with behavior disorders and to determine the degree of disturbance;
3. Individual counseling service with teachers, parents, and children to modify attitudes and behavior which lead to problem situations, with referral to the child-guidance clinic for more thorough diagnostic study, or to other community agencies as indicated;
4. Group therapy with parents to help parents gain in understanding of their own and their children's problems, and to modify early sources of disturbances;
5. Group therapy with children, particularly adolescents, to provide an opportunity for them to work through their problems of personal and social relationships more satisfactorily; and
6. Inservice training for school personnel to present basic concepts of preventive mental health through case conferences, group-discussion leadership training, and other types of study groups.

Within this framework, then, the program in a given school develops according to the needs of the school and the resources available, as determined by the school district and the health department. Some districts have the complete program, with several hours of service a week in each school of the district. Others have the full service in only one or two schools. In one district which employs its own two trained social workers there is no direct service to children or parents, but consultation and inservice training are provided teachers and school personnel.[8]

Despite the broadening of the Mental Health Service, group therapy or group counseling are getting renewed emphasis since this method appears the most likely to reach the most people and to make the most efficient use of limited professional personnel for therapy. Further, group therapy is the service of choice for many problems in which parent-child relationships are involved. More mothers' "study groups," with mothers of children of similar ages or grade placements, are now functioning. These groups, usually with 15 to 18 members—now not limited to mothers of disturbed children—meet weekly with a worker for 5 or 6 weeks to discuss child-rearing problems. Mothers participating in these more broadly constituted groups seem to find the experience valuable. No longer is there the uneasiness that sometimes generates in a group made up only of mothers selected because of specific child problems. Smaller therapy groups can be developed from the larger ones when more intensive help is needed.

Group therapy with adolescents—another development—grew out of increased requests for service from the high schools. In the second year of the school mental-health service program, 2 groups of boys—6 in one, 8 in the other—in 2 high schools were organized. These boys had been referred by the high-school personnel because of behavior disturbances, usually of an aggressive, acting-out nature. They met with a worker weekly for an hour's discussion during the school day in the school building when unstructured, permissive talk about problems, feelings, and attitudes was encouraged.

In succeeding years when the total school program has expanded, this high-school program of group therapy with adolescents has also grown as a preventive mental-health service. Eight groups (4 of boys and 4 of girls), involving 58 adolescents in 5 high schools, met last year. One indication that this service is accepted by the students themselves is the fact that approximately a third of the youngsters in the groups asked to join.

Work with classroom teachers and other school personnel, through counseling on individual problems and small-group discussions, has become still another increasingly important activity. Conferences are planned with small groups of 5 to 10 teachers in a given school to discuss problem children and the mental-health "climate" of the classroom. Some of these conferences are led by a teacher, with the mental health worker serving as a consultant. Others are led by the worker. The constant purposes is to increase the teacher's understanding of mental-health problems and of his relationships with children and to enable teachers to handle these more effectively in the classroom.

Consultation with teachers must always be a mutually shared experience, a learning experience for each person involved, rather than a one way communication. These inservice teacher-study groups have 10 to 15 sessions, each lasting 1 to 2 hours. Content includes "Understanding the Emotional Needs of Children," "Personality Development of Children," "Mental Health Climate of the Classroom," and similar topics as agreed upon. The mental-health staff person presents brief lecture material with or without films to focus discussion. Several schools give salary increment credits to teachers who voluntarily participate.

In our opinion school mental-health programs, developed cooperatively by schools and health departments, may well become the most effective preventive community mental-health program. These programs can be "tailormade" to meet the needs of each community. Our experience indicates there are wide variations in needs, understanding, and other characteristics of school communities which must be taken into account. Also the contract method described provides opportunity to integrate professional staff and community resources.

Future Developments

Continued experience will undoubtedly condition the further development of community programs of the mental-health service. Already a number of areas where planning and implementation of activities need to be undertaken experimentally have been identified.

Development of a coordinated plan of service to delinquents, which has been started this year by the health department and the juvenile-court probation office, presents an opportunity to learn more about problems of delinquency, from the individual and community points of view, and to develop resources for prevention and correction. As time goes on, through continued diagnostic study of individual cases brought to the court and referred to the service, and through more effective studies of communities in the county from which delinquents come, helpful knowledge of the delinquency problem as it exists locally will undoubtedly be gained. Additional resources, such as residential-treatment facilities, and plans for the use of group-therapy techniques are needed. A study is at present underway in the community, under the auspices of the county council and the Social Planning Council (the council of social agencies), to determine the most effective use of bond-issue funds recently voted for a building for the care of children. A Greater St. Louis Youth Commission has been recently appointed by the city and county administrations to explore problems of juvenile delinquency and methods of dealing with them. The health department, along with others, is in a position to be a resource to the Commission.

Understanding the Community

In addition to studying problems of juvenile delinquency in communities, the staff working in the school mental-health service has become increasingly aware of the need to understand the community in which a school is located. Such factors as concentration of population, cultural background of the population, socio-economic levels, community organization, and other social and environmental data are of significance in determining both the needs of the school community and the specific mental-health program to be developed in and through the schools.

Developing methods of screening and evaluating children with behavior disorders is another interest of the staff in the school mental-health service. Initial research indicates that a symptom inventory reporting number, frequency, duration, and severity of symptoms of a child as observed by his mother can be a useful screening tool.[9] Increased skills on the part of mental-health workers in evaluating and classifying degree of disturbance into the four groups previously described is necessary if an effective program of service is to continue to develop. Methods of dealing with school problems cooperatively by the school and health personnel when parents are unavailable also need further exploration.

The child-welfare division of the county office of the State Department of Welfare has requested case consultation for their social workers. Integrated planning between the personnel—medical, psychiatric, psychological, and social work—of welfare and health agencies can lead to further development of preventive mental-health services in this area. Inservice training of staff through group consultation on mental-health problems, clinic diagnostic and treatment service for parents requiring this kind of service, group therapy for mothers and foster mothers of children under a welfare agency's care, are all potential services to be considered.

Plans Underway

One area of importance in the consideration of mental-health needs, so far not touched upon, is work with the preschool child and with the parents of preschool children. Since behavioral patterns are begun and established early in life, preventive mental-health work with parents of infants and preschool children is of great value. The well-baby clinic of the health department is a natural institution in the community for the development of services in this area. During the past few months, conferences have been held between the physicians of the preventive-medicine division responsible for child health, the director and supervisors of the nursing division, and the director of mental-health service to discuss potential services. Mental-health education programs that utilize films and other audiovisual tools for group discussion with mothers, and early screening and spotting of disturbances in children and mothers are being considered for the future when staff is available. Tentative plans call for initiating a program in one clinic, on a demonstration basis, which would involve the pediatrician, nurse, volunteer, and mental-health worker.

Training programs for professional persons in the field of mental health are seriously needed. St. Louis is fortunate in having two universities which have medical schools with departments of psychiatry, departments of psychology for graduate training, and graduate schools of social work. Plans have been completed for developing a training program in the health department under contract with one of the universities, beginning July 1956.

This initial training program is to include residency in child psychiatry, internship in clinical psychology, and field practice in psychiatric social work. Inherent in the training program is the need for continued sound staff structure in the service division, and competent consultation and training resources. Some period of experience in carrying on such a training program should make it possible to determine more accurately the kind of training necessary for "community mental health" personnel.

When the mental-health service was established, the health-department administration and now the service's staff were aware of the need to evaluate the new program as it progressed. Application was made to the U. S. Public Health Service for a research grant through the National Institute of Mental Health. Such a grant was made. As a result, a research division in the mental-health service was established in 1953 with a director and staff. The present program of this division is to evaluate the effects on child behavior of parental attitudes toward child rearing and the effects on parental attitudes of the service and education programs.

As Kotinsky and Witmer have pointed out, there are many and varied approaches and very little coherence in the field of community mental-health endeavors.[10] The St. Louis County Health Department program is one attempt to develop a community-wide preventive program. We hope that our experiences, with those elsewhere, will contribute to the development of services which will more effectively meet community needs.

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Impressions from an international conference . . .

SOCIAL WORK FOR CHILDREN AROUND THE WORLD

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REPRESENTATIVES of 53 countries participated in Munich, Germany, last summer in the largest international assembly of social workers ever held. This, the eighth conference, had over 2,600 registered delegates, all concerned with the effect of industrialization on social services.

The reports of the 20 study groups will be a valuable resource of facts and opinion when they become available in the next few months. The brilliant papers read at the plenary sessions are already available in one or more of the three official languages, English, French, and German, as are the scholarly reports prepared in advance by four commissions.

At this time, however, one can only share some of the impressions which came as a result of meetings, agency visits, and conversations with others about their programs for children.

Children and their development were at the center of so much of the discussion that the entire conference could almost be called a child-welfare project. Nearly every one of the countries represented reported that children have a high priority in their planning. That this was more than an attitude became clear to American participants not only through what they heard at the conference but what they saw in visiting other countries before and after the meeting.

The conferees saw the position of children in an industrialized society as a most vulnerable one. In one phrasing after another the question arose: "How do we guarantee for children a wholesome family life, free from fear or want, and still concentrate them and their families in an urban community around the industrialized means of production?" On the whole, however, they did not look on concentration of people as a certain prelude to family breakdown or problems for children. A probation officer in Hong Kong and a social worker from Pakistan, both referring to very crowded housing and substandard living in their homelands, reported low delinquency rates. Moreover, said the delegate from Hong Kong, few of the children brought to the attention of the courts there showed evidence of severe problems. Though these and other comments were not conclusive, they produced a great interest in finding a cause for the difference between this and the experience of American courts. There seemed to be widespread agreement that the low incidence of juvenile delinquency in these Asian countries was to a large extent related to the strength of the family unit and the controls on behavior that prevail.

This same theme emerged in several of the major addresses and in many of the study groups: The family as a unit is the core of the success or failure of child development and, hence, of the health of the community itself. Attempts to relate the quality of family life to the presence or absence of industrialization in a community were not conclusive. While evidence of a close statistical correlation between industrialization and family breakdown was generally accepted, few persons saw this as proving a cause and effect. Evidence was produced to show that where family life had been protected by adequate housing and continuation of family-centered culture patterns through decentralization of industry, in industrialized communities, child rearing was not adversely affected. While no one denied the existence of dangers in industrialization, there seemed to be a firm belief that the problems could be solved and that industrialization was not a development to be avoided. How to guard against its bad effects while enjoying its material benefits became the focus of concern.

Many participants called for greatly increased research to evaluate objectively the subjective effects of urban living on family and child life. Few could report in more than general terms on the meaning of the varieties of family life described. For example, a British speaker in a plenary session asked: "What do we know about the dual culture of the factory and the home? In the factory with its special customs and group sanctions a man may be stable and cooperative. In his home this same man may be a tyrant and quite unable to maintain his stability. The factory has become another life and his family cannot share in it."

An Austrian child-welfare worker asked: "Is it not difficult for a child to continue to have respect for a father who, though he is the only means of support for the family unit, cannot be sure that his job will last through the month?"

A delegate from India reported that many of the village people in his country had moved prematurely to cities. With no work and little social service, the family suffers, said he, but at least it is together. When at last work is provided, the father, and sometimes both parents, leave the children at home.

Dramatic Changes

Obviously such dramatic changes must have serious effect on children. We need to know more about the child's feelings in such instances and about what will carry over to his maturity.

Thus the conference pointed up the vast difference between the life and relationships of a family as a producing unit in a rural setting and of a family with a producing individual in an urban setting. Planning for this transition, many of the conferees agreed, should come before and during the shift. Adequate housing and social services to meet the needs of workers and their families should be considered along with plant location and availability of resources.

The conference offered extensive opportunities to learn something of the cultural differences which might influence the function of child-welfare services. Speakers at the general sessions and in the study groups gave many illustrations of special needs and problems growing out of national history, religious beliefs, or the customs of community and family life. Representatives of every country emphasized the importance of attention to the culture of a people when planning is being done and gave some evidence to show that the way an industrialized community develops will be influenced by the local culture. Some countries, a United Nations representative reported, have already demonstrated an ability to develop an industrial community without destroying kinship ties. Newly industrialized countries, it was indicated, need not go through the same experiences during industrial development as the older industrialized countries. They may be expected to profit some from the mistakes as well as from the more positive experiences, and even the latter may require adaptation to the local culture and local conditions.

Such statements brought home the necessity for caution in applying the methods and philosophy of the social-work profession directly from one country to another. The Americans among us realized anew that American child-care methods have grown, and will grow, around the problems, available skills, and mores of America. The social workers from other countries showed that they also were recognizing this. They seemed to want to know about our methods and to study our theory but gave evidence of being increasingly careful to avoid attempts to apply these directly in their own communities. This suggested that Americans might make a larger contribution by sharing their knowledge and experience "on the ground" in other countries, rather than by bringing social workers to America for training. Younger social workers particularly reported disappointment and discouragement at not being able to apply training gained in the United States and difficulty in adapting their new knowledge to the local scene without the help of their teachers.

This observation on training is, of course, only an impression which has not been objectively tested. There also seemed to be great enthusiasm over instances in which leaders from the United States had conducted seminars abroad or cooperated in foreign schools of social work.

Other Impressions

Among the numerous other stimulating and thought-provoking impressions this writer brought back from Munich and other parts of Europe were:

Impression: Institutional programs for children in much of the rest of the world are far below American standards. This seemed especially true in the ratio of personnel to children. Equipment, on the other hand, seemed generally fair and often quite satisfactory. Some of us observed a day nursery in which the building and furniture were as good, or better, than any I had seen in this country. The same could be said of its health protection, but it had three staff workers available for direct contact with 60 children. A reception center for difficult girls had 4 workers trained as teachers for 50 rebellious teenagers. A boys' "study home" with a very intelligent and sensitive young man, trained as a teacher, as its head had no psychological testing service, "except in very special cases in which we can ask for testing by the school psychologist."

Skilled, well-prepared social workers with major responsibility for children were lacking in every children's institution in seven of the major cities we visited in Europe. In most instances, the agency heads themselves deplored this and expressed a desire for training and special education for themselves and for at least some of the staff.

Impression: Methods of treating and rehabilitating handicapped children seemed modern and effective but were insufficient to meet the need. This also seemed true of all children's services. Pilot programs and brave new starts were abundant.

Impression: Except in Great Britain casework as we know it is rarely practiced in social work in other countries and, with some notable exceptions, social workers themselves are not urging its adoption. They are faced with the survival needs of children. They say that the lost and abandoned boys in the large cities of Europe give up their stealing when they no longer have to steal in order to eat; that families that are struggling for space and air do not require counseling, let alone casework therapy, but need housing. This last is going up rapidly all over Europe.

Impression: In the Scandinavian countries and elsewhere also, the provision of services to working mothers has a high priority. While the conference speakers reiterated the importance of a mother's being available to her children, economic pressures were continuing to make extensive day-care services essential. Day-care agency personnel exhibited surprisingly little concern over the effects on the personality development of a child of sharing a substitute mother, the nursery-school teacher, with 40 or 50 other toddlers.

From a health and educational point of view the nurseries I saw generally had very good provision, often above the standard in our own day-care service. The schedules were optimum for the mothers and fairly reasonable for the children. When asked, we Americans described our best service as much better than theirs but admitted that our day-care program was not meeting our needs and was certainly not up to standard in every instance. We were not able to report an agreed philosophy of day-care service among American social workers.

Whose Responsibility?

The foregoing are impressions, but one theme can be reported as running deep and strong in all the conference meetings. It was composed of two questions: First, to whom do we look for the leadership in *planning* the sound organization of an industrialized society; and then, whose is the responsibility for support?

Those countries which have had the longest history of industrialization made a plea for citizen participation in community planning. They urged that the planning be done far enough ahead to make it a thoughtful effort. We were reminded that social workers, who have historically been so close to the good and bad effects of industrial change, must recognize their responsibility for participation in planning and goal-setting; that we must redevelop our long dormant "social leadership attitude."

No general agreement was apparent over the answers to these questions. Many European countries seem to emphasize programs in which industry itself provides the entire range of social services from prenatal care and day nurseries to health and counseling provisions. In others, such as Korea, voluntary agencies are attempting to carry the responsibility for much of the developing service. In the Scandinavian countries and in Yugoslavia the state is assuming a major responsibility. Most of the participants seemed to recognize that industry itself has a heavy responsibility whether directly or through support of the voluntary services, and that its responsibility is especially great for its own workers. The American delegates were called on frequently to describe their concepts of the community-organization approach.

Though opinions were far from unanimous, one fact clearly emerged: Coordination of planning is difficult because technical advance is rapid and social planning is slow. To this observer this does not seem like an insurmountable obstacle. It would seem to call for the development of relationships between social planners, industrialists, and social workers, so that the people involved might avoid the dangers while enjoying the benefits of industrialization. As an eloquent delegate from India said, "We have no reason to fear or shun industrialization. It will come and is potentially good, but we must be ready for it."

PROJECTS AND PROGRESS

World Federation for Mental Health

Children, especially children in school, were a major focus of attention of more than 500 psychiatrists, psychologists, social workers, public-health workers and educators from 31 countries, who came together in Berlin in mid-August for the 8th annual meeting of the World Federation for Mental Health. They met in plenary and technical sessions, aided by a system of simultaneous translation, and in work groups where translation, when needed, depended on the skill and good will of the participants. Each of the 12 work groups tackled the mental health aspects of a single problem, the subjects including, among others, vocational education, teacher training, religion, defective children, leadership. In addition a section to view and discuss mental-health films met daily.

Obvious throughout the 5 days of the meeting was the participants' deep concern over the problems faced by parents, schools, and communities to rear stable children in an unstable world. The setting itself—a split city where material contrasts and high tension are apparent to the most casual visitor—was a constant reminder of the emotional strength today's children will need to bring stability to the world and of the difficulties today's adults face in helping them to achieve it.

No recommendations were made and many questions remained unanswered. How, for instance, to keep the world from falling prey to mentally sick leadership? Would it be possible to "screen" prospective leaders psychiatrically, as airplane pilots and others on whose health depends the safety of others are screened for physical defects? Or could the world only be protected from mentally sick leadership by the building of mentally healthy populations who could not be taken in by demagoguery?

The consciousness of global problems and the place political solutions will have in nourishing or thwarting the mental health of future generations did not divert the participants from careful consideration of the immediate problems of parents, schools, and children. Here, too, many questions remained unanswered.

Help us, one American educator pled, to make up our minds about an unsettled controversy in our country. Should slow learners be put in special classes? Is the stigma of being so placed worse than the shame of being unable to keep up with the class? How do we reconcile our responsibilities to the slow, the gifted, and the average?

He received no answer, but evidence that this was not just an American problem came up again and again in papers and discussions. The weight of present experimentation seemed to be on the side of special classes, but there was also evidence of recognition that behind a lot of slow learning might be something other than intellectual inferiority.

How complex the problem can be was described by a professor of child guidance from a university in East Berlin who maintained failure in school to be a result of the whole personality development—including the child's own low self-evaluation and the low social evaluation given him by his teachers. This speaker was also concerned with gifted children, who, he said, had more problems at puberty than average children and who, he advised, should not be allowed to become "stars" but should be stimulated to perform at the peak of their ability. An American educator, seeing slow learning as resulting in behavior problems and school dropouts, related these to "the unreality of the school in relation to the natural drives of youth."

Nobody made any claims of having a blueprint for solving all the problems of school adjustment, but descriptions of what some countries are trying to do were presented with hope and also with frank acknowledgment of shortcomings—particularly inadequate financing and personnel shortages. A Swedish educator described the difficulties of carrying out instructions of the Swedish Board of Education for all schools to make "medical, intellectual, psychological and social" investigations of students with difficulties. In Stockholm, said he, there are two school psychiatrists for 50 schools, having a total 70,000 pupils, while smaller school systems have no such professional aid. Great reliance, he said, had to be placed on intelligence tests and on the ability of school nurses to help iron out pupil-parent-teacher conflicts through home visits.

In Great Britain, reported a British child psychiatrist, special schools for maladjusted children have become part of the network of psychological services under the administration of the Ministries of Health and Education, and recommendations are now before the Government for expansion of these and other services and for training personnel for them. While child-guidance clinics in the past have placed major emphasis on helping school children, they now are becoming increasingly concerned with finding ways of helping preschool children and of reaching "the sizable group of seriously disturbed children in the community" whose parents will not cooperate in treatment.

The relation of preschool life to school adjustment received considerable emphasis, especially by British, French, and American speakers. Aside from the mother-child relationship cited repeatedly as crucial, preparation for school was brought out as an important factor. If a child expects school to be a good experience the chances are that it will be, said a British psychiatrist, but if he approaches it with foreboding because he has been led to believe it is a necessary evil, trouble lies ahead, and the same holds true of expectations of work. A French neuropsychiatrist pointed to the importance of kindergartens in helping to wean a child away from too much dependence on the mother. The mother, he said, has a double duty—partly to protect so that the child feels secure and partly to withdraw so that the child may develop aggressive independence.

An American psychiatrist described a study to delineate early signs of motherliness or child rejection by observing the actions of a selected group of new mothers during breast feeding in the first week of their child's life.

Some delegates reported special symptoms of unrest among the young of their country—an epidemic of addiction to "awakening drugs" in Japan, an increase in children with "inability to concentrate" in West Berlin's schools.

Methods received attention as well as

problems and programs—group therapy, psychosomatic medicine, epidemiological studies of mental illness, the place of social casework in a mental-health program. The part ingenuity can play in revising methods to fit circumstances emerged clearly when a psychiatrist from the Sudan told of how he had had to combine professional skills, cultural knowledge, and help from untrained personnel to cope with the problems brought to him.

The gaps in knowledge received recognition too. What part, for instance, does heredity play in the development of neuroses and psychoses? The question was asked by an Austrian psychiatrist, who called for more statistical research on the subject. But he, in a sense, typified the meeting's atmosphere of urgency when he pointed out that we do not need to wait for all the answers before making greater efforts to reduce the "releasing factors" by manipulating social environment, spreading mental-health principles, and seeing that therapy is available for the possibly susceptible at the crises periods of life.

—*Kathryn Close*

Radiation

Effects of radiation on human heredity were considered by a study group consisting of 20 scientists from 9 countries at a meeting held by the World Health Organization at Copenhagen, Denmark, August 7–11, 1956. Included were radiologists, statisticians, public-health administrators, and specialists in human and other branches of genetics.

Expressing the opinion that as yet not enough is known to permit assessment of the extent and importance of radiation effects on man, the group stated that it agreed essentially with the findings published recently by the National Academy of Sciences, United States, and the Medical Research Council, Great Britain (see page 203), and also with a resolution on radiation damage to human heredity adopted recently in Copenhagen by the First International Congress on Human Genetics.

The group recommended that research in genetics, especially human genetics, be intensified; that steps be taken to reduce the shortage of teaching facilities in genetics and of trained geneticists for research; and that efforts be made to reduce the hazards from man-made radiation from sources used in medicine, industry, commerce, and experimental science. A broad indication was also given of some fields of research in which new advances might be made.

Countries represented included Brazil, Canada, Denmark, France, Germany, India, Sweden, the United Kingdom, and the United States.

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The Ninth World Health Assembly, which met in Geneva, Switzerland, in May, approved a program for 1957 for protection against the hazards of industrial use of atomic energy, covering training of public-health personnel, development of standards, and studies of health risks connected with radiation and radioactive waste disposal.

Mental Health

A census of emotionally disturbed children in Rhode Island taken by a committee formed for the purpose indicates that 9 of every 1,000 children in the State are emotionally disturbed. Twenty-eight health, welfare, and recreation agencies, 26 public-school departments, and parochial schools in 5 communities reported that 1,678 children 4 through 20 years old had serious behavior problems primarily attributable to an emotional disturbance. The reporting agencies used a working definition of emotional disturbance provided by the committee. Children whose chief problem was mental retardation were excluded.

About one-third of the children had received services from various agencies such as child-guidance clinics, and about half were known to health and social agencies not primarily geared to serve disturbed children: but 280 (one-sixth) had had no contact with any such resources. Services that had been recommended for 318 children were not available to them either because of difficult family attitudes, limited staff and facilities, limitations in geographic coverage by the service, or total lack of the specific kind of service indicated. For 7 children in every 100 no plan at all had been made. Although study and treatment of the children in residential centers was seen as an ultimate resource, to be used only after other resources had been tried and found inappropriate, the reporting agencies recommended this type of care for more than 20 percent of the 1,678 children.

The committee was established by the Pawtucket and Blackstone Valley Council of Social Agencies, the Rhode Island Society for Mental Hygiene, and the Family and Children's Division of the Council of Community Services of the Providence metropolitan area. The Council of Community Services' Research Bureau aided in the design and conduct of the census and analyzed the findings.

In its report, the committee describes its figures as representing "a conservative count," and urges further study of the problem, leading to action "before it becomes overwhelming."

For Indians

Since the transfer of Indian health activities to the Public Health Service on July 1, 1955, about 100 physicians and dentists and 200 other health workers have been added to the Indian health program. The appropriation by the 84th Congress of $38,775,000 for the program for the fiscal year 1956–57 is 11 percent greater than in the previous year, the first in which the Public Health Service carried this responsibility. With a separate appropriation of $8,762,000 for construction and repair of hospitals and other facilities, four hospitals are to be built this year, three of them replacements, in addition to some staff housing.

During the fiscal year ended June 30, 1956, an increase of 42 percent in the appropriation for Indian health permitted much extension and improvement in health services. Besides providing such services through its own staff and its own 56 hospitals, the Public Health Service made contracts with about 30 State or local health departments and many private physicians, clinics, and dentists to provide such services, and with four universities to help in bringing tuberculosis and other diseases under control. During that year hospital admissions and hospital outpatient treatments among Indians and Alaska Natives increased by 10 percent over those reported for the previous year. Also, during the 1955–56 fiscal year the Public Health Service trained 90 Indians for such occupations as sanitarian aide, practical hospital nurse, and dental assistant.

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The 84th Congress also directed the Secretary of the Interior to conduct an investigation of Indian education in the United States and Alaska, including the study of education problems of Indian children from non-English speaking homes and the possibility of establishing a more orderly transfer of Indian children from Federal to public schools.

Health Survey

A continuing national survey of the health of adults and children in the United States will be carried out by the Public Health Service, Department of Health, Education, and Welfare, under authorization of a law enacted by the 84th Congress at its second session. (Public Law 652, approved July 3, 1956). Periodic supplementary studies were also authorized. Congress appropriated $700,000 to finance the program for the fiscal year beginning July 1, 1956.

The information to be collected will include the extent, distribution, and effects of various illnesses and disabilities and the services received in connection with them. The Public Health Service was further authorized to develop and test new or improved methods for obtaining current data of this kind.

Juvenile Delinquency

Twenty-one States and the District of Columbia now have special units of the State government concerned with juvenile delinquency. California, Illinois, Massachusetts, Minnesota, and Texas have separate departments to develop and administer a program for the control and treatment of delinquency. Five other States—Maryland, Pennsylvania, Washington, Wisconsin, and Idaho—have established in an existing State department a bureau or a division concerned with delinquency. Twelve States have established State commissions or committees with the responsibility, either as a sole function or as part of a broader child-welfare assignment: to study the prevalence of delinquency in the State; to plan measures designed to combat delinquency; to coordinate existing services; and to give consultation to operating programs. This group includes Delaware, the District of Columbia, Florida, Louisiana, Michigan, Mississippi, New Jersey, New York, New Mexico, North Carolina, Tennessee, and Wyoming.

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New York City recently allocated $100,000 a year for a 5-year comprehensive study of the various methods used by public and private agencies and by citizens groups to control juvenile delinquency in the city. Directed by a sociologist, the project has two assistant directors—a sociologist and a social worker—and employs seven research workers from the fields of political science, law, sociology, education, and social work.

The project will make findings public from time to time during the period of the study so that the groups involved may take advantage of them to make their work more effective. Among the agencies whose work will be evaluated are the Youth Board of New York City, juvenile and youth courts and their probation departments, the juvenile services of the police department, institutions for delinquents, detention homes, child-guidance clinics, and community organizations.

Health Education

To combat public ignorance of why and how records of birth, stillbirth, death, marriage, and divorce are kept, Tennessee's Department of Public Health is taking steps in several counties toward interesting the younger generation in such recording. For more than 2 years the Department's Division of Vital Statistics, with encouragement from the Public Health Conference on Vital Statistics, has been working with public-school authorities to familiarize high-school students with the various types of official certificates and to explain the importance of statistics based on vital records to the individual and the public.

A mimeographed manual for students has been prepared that includes graphs, illustrations, and sample copies of official certificates, with descriptions of their use. It includes eight chapters on the major phases of vital statistics, a summary, glossary, and tests. Teaching aids used with the manual include a motion picture, a talking film strip, a miniature exhibit, a puppet show, posters, and charts. The teaching unit has been used in 9th to 12th grade classes in American history, civics, English, health, home economics, and sociology or social problems.

Adoptions

Nearly a hundred doctors, lawyers, nurses, psychologists, and social workers from nine States attended the Rocky Mountain Regional Conference on Adoptions, in Estes Park, Colo., September 10–12.

The Conference was sponsored jointly by the Colorado State Department of Public Health, Colorado State Department of Public Welfare, University of Colorado Medical Center, and the Children's Bureau, Department of Health, Education, and Welfare. Its planning committee, under the chairmanship of a professor of pediatrics of the Colorado School of Medicine, included pediatricians, a psychiatrist, a juvenile-court judge, an attorney, and medical social work and child-welfare administrators.

At the general sessions a pediatrician described the doctor's role as a threefold medical function: to evaluate the physical condition of the child; to provide prenatal and obstetrical care to the mother; to assist prospective adoptive parents in securing examination and treatment for fertility and to provide them with medical evaluations as to their suitability to be parents.

An attorney, stressing the fact that lawyers are not trained to select adoptive homes for children, said that they have an important role to play in pointing out the legal safeguards in adoption. In many instances, he said, attorneys who are legislators are also in a position to see that sufficient money is made available for the support of good adoption services.

A social worker, who has studied adoption practices throughout the country, emphasized the need to recruit adoptive homes for older children and children in minority groups.

A consultant from the Children's Bureau Division of Social Services, asserting that legislation alone cannot provide adequate protection to the child, stressed the importance of interpretation, teamwork among professions, and evaluation of adoption-agency policies. Development or expansion of services to parents—married and unmarried—to children, and to adoptive parents are essential, she maintained.

A panel of judges presented a résumé of the laws affecting adoption in the nine States.

Subjects under discussion in three interprofessional work groups included the rights of unmarried mothers and their need for adequate medical, financial, and counseling service, sound termination of parental rights, basic criteria for good adoptive parents, problems regarding rejection of adoptive applicants, medical and social evaluation of the child considered for adoption, concepts of "adoptability," problems in placement of the young infant or the older child, need for interpretation to the public, and specific functions of an interprofessional team working for the best interests of the child placed for adoption.

A summary report of the conference will be made available early in 1957.

Handicapped Children

The Office of Education, U. S. Department of Health, Education, and Welfare, is undertaking a program of research on educational problems of the mentally retarded, with $675,000 made available by Congress for this fiscal year. The funds will be used for cooperative research with colleges and universities or with State departments of education to study such problems as standard definitions and terminologies; to collect and collate research studies in mental retardation; to investigate the qualitative and quantitative aspects of learning among various categories of mentally handicapped children; and to evaluate organizational and instructional techniques in school programs for such children.

A 2-year survey of blind children in New York State and of the services available to them was begun recently by Syracuse University with a grant of $60,000 from the E. Matilda Ziegler Foundation for the Blind. Schools, agencies for the blind, hospitals, and other organizations that are likely to be helping blind children are already answering a questionnaire designed to find out what agencies are serving blind children. Later these agencies will be asked for detailed information on each blind child served.

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Alabama's services for children with oral cleft are soon to become more easily available to children all over the State, through a 5-year project recently begun by the Crippled Children's Service, State Department of Education, in cooperation with the University of Alabama. The Crippled Children's Service, which for a number of years has provided complete diagnostic and treatment services at the University's school of dentistry, Birmingham, for children with this handicap, is joining with the school and the University's department of speech to give the same complete care at three or more facilities located in other parts of the State. This care includes the services of a dental surgeon, a general dentist, an orthodontist, a prosthedontist, a nurse, a medical social worker, and a plastic surgeon. The plan for providing the care includes training local physicians and dentists for dealing with the handicap.

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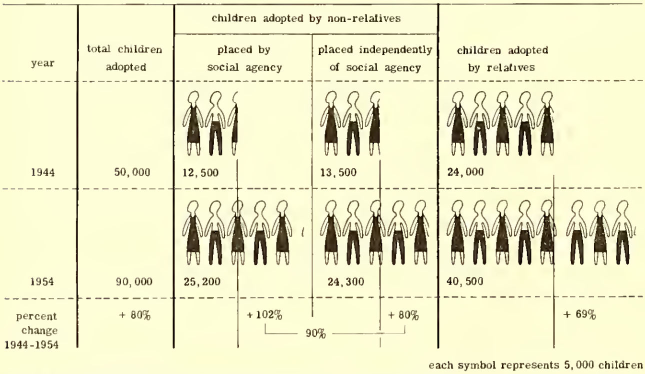
GROWTH OF ADOPTIONS—CORRECTION



Estimated totals for the United States based on data transmitted by all States reporting in 1944 (22 States) and in 1954 (37 States). Detailed distributions estimated from comparable data from 14 States reporting in both years.

Through an error, detected too late, a chart on adoptions presented in the last issue of this journal was based on figures which are not directly comparable. The chart above presents estimates based on consistent definitions of terms. These confirm the major trend in the previous chart: the marked increase in adoptions by nonrelatives. The corrected figures, however, indicate that placements by social agencies have increased more, proportionately, than independent placements. The latter, however, still comprise nearly half of the total of adoptions by nonrelatives.

Child Welfare

Under State legislation which became effective in April 1956 Michigan's State government now shares with the counties the cost of foster care for children. Mandatory provisions of the act require counties from which delinquent, dependent, or neglected children are committed to State facilities to pay half the cost of their care; previously the State paid the entire bill. On the other hand, under permissive provisions, the cost of foster care given in the child's home county, which previously had to be paid entirely by the county, may now be borne partly by the State if the county meets certain conditions and standards. To be eligible for reimbursement, the county must establish a new fund for foster care and spend from it an amount at least equal to 15 cents per $1,000 of its property value. The State may reimburse a county annually for 90 percent of the first $2,000 expended.

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Recent State legislation has given the South Carolina State Department of Public Welfare responsibility for licensing agencies, institutions, and family homes which receive children for care and maintenance, either full time or part-time.

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Mississippi's legislature at its 1956 session appropriated funds to support the State Children's Code Commission for the year beginning July 1, 1956. Previously the Commission was partially supported by Federal funds.

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In Connecticut the Greater Hartford Community Chest recently made $30,000 available to a voluntary agency, Children's Services of Connecticut to demonstrate the value of social services to children in their own homes.

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California's State legislature recently enacted a law permitting county welfare departments to provide services for children in their own homes.

READERS' EXCHANGE

HOWARD: *About selection*

I have read Mr. Howard's article on institutional treatment with some interest and question. ("If Institutional Treatment is to Succeed," by Frank M. Howard, CHILDREN, September–October 1956). I have no doubt that the approaches it describes should bring about the desired results. The author, however, is referring to institutions which offer services to children with mild or moderate emotional disturbance. Here time is available for the accepted institutional practices of proper referral, selected intake, adequate preparation, and the like. The title and tone of the paper imply that institutional success can be achieved only through such procedures, with which I must disagree.

What about the institution which caters to delinquent or seriously disturbed children? Here opportunities for preparation are limited, because of the pressure for immediate action due to the nature of the disturbance and its effect upon the community. The youngster's acceptance of placement usually becomes an institutional responsibility rather than that of the referring agency. Actually, preparation for any institutional placement can never be thorough enough to remove all fear and anxiety. It is the involvement of the youngster in the institutional program, his relationship with caseworkers, groupworkers, other staff members, and his peers, as well as his personal problems and personality, which will determine the nature of his institutional experience.

I have considerable question about Mr. Howard's concept of group pressure as a factor to be considered in attaining proper population balance. Group pressures exist but not on the basis of symptomatic behavior. Neither homogeneity nor heterogeneity is achieved by concentrating on symptoms. The child who steals only certain objects may be quite different from the youngster who steals only to get caught. Group pressures for or against stealing may have nothing to do with past experience, but be related entirely to institutional phenomena. This matter is important because institutions usually choose their populations through evaluations of social-history material.

Institutions are becoming increasingly selective. Although this may be based on sound professional thinking, I feel that they can very well receive many youngsters who are now being rejected for reasons related to varied concepts concerning group selection or contamination. These theories fail to give sufficient recognition to the strength of the institutional climate consciously applied to bring about change in behavior and direction.

Abraham G. Novick
Superintendent, New York State Training School for Girls, Hudson

NORRIS: *Reply to critic*

Dr. Lowenfeld's letter in the September-October issue of CHILDREN (Readers' Exchange, page 199) illustrates the hazards involved in communicating research findings and implications in a brief article.

In quoting "the most significant finding" of the Chicago study Dr. Lowenfeld omits the most important implications by using only part of a statement as presented in the article: "The development of the blind child with no major physical handicap can be expected to progress in orderly fashion *so that by school age he is functioning well up to the level of his sighted peers. This development, however, takes place only to the extent that overall conditions have been favorable for him.*"

The complex interrelationships between the child's development and his total life experiences are basic to the conclusions of the Chicago study which go farther than those of Gesell or the Perkins conference mentioned by Dr. Lowenfeld.

In answer to Dr. Lowenfeld's other comments the following conclusions should be restated:

1. When children were grouped by degree of vision there was no evidence that the children with some vision were better oriented as a group than the children with no vision. In orientation as with the other variables, degree of blindness in itself does not appear to be the determining factor. Moreover, a child's psychovisual efficiency was found to be much more closely related to his general functioning level, in itself a reflection of his life experiences, than to his eye condition. In particular, opportunity for wide experience in the development of gross motor skills appears basic to the achievement of proficiency in orientation. Following the children into school age will shed further light on this question.

2. Children with retrolental fibroplasia, in spite of the time spent in the premature nursery, did not develop with greater deficits than children blind from other causes. The quality of the parent-child relationship seemed to be a major influence on the child's development. In most cases problems in relationship could be minimized or prevented by skilled counseling help to the parents from the time of diagnosis onward.

Miriam Norris
Elizabeth McCormick Memorial Fund, Chicago

STEVENSON: *Experiences needed*

It is gratfying to read Dr. Stevenson's clear-cut exposition of current theoretical bases of prevention in mental health, and his delineation of obstacles in the way of community action. ("The Search for Mental Health," by George S. Stevenson, CHILDREN, September-October 1956.) Yet he may have oversimplified one phase of a wide and complicated topic, in designating "citizen immaturity" as the most common reason for shortcomings in community mental-health services.

True, citizen leaders are often sadly lax in accepting responsibility for organizing and guiding community action in mental health. But perhaps the deficiency comes from more than *not knowing* how to focus their efforts in today's complex community life. It also stems from how they are motivated and how they learn.

Mental-health workers, too often impatient to achieve their own goals, have not applied their professional knowledge frequently enough in work with community leaders. We still are prone to rely upon persuasion, exhortation, salesmanship, and even pamphleteering. Often we do not bother to find out where the citizens are in their understanding and attitudes, so cannot "begin where the learner is."

For citizens to learn to exercise the leadership in community mental-health planning which Dr. Stevenson shows is so badly needed, dynamic experiences must be provided in democratic functioning as planners, organizers, policy makers, and evaluators. And these learning experiences must be tailored to the individual's and group's particular situation. We professional workers must first look to our own skills in consultation techniques and group methods if we are to be effective in helping citizens to "mature."

Charles F. Mitchell
Director, Division of Mental Health, Texas State Department of Health, Austin

WORK: ***Another example***

The group of articles on the change of attitudes and expanding services to children in hospitals was very gratifying. ("Making Hospitalization Easier for Children," by Henry H. Work, CHILDREN, May–June 1956). Your readers might be interested to hear of our program, which has been in operation for the past year. It deals with both long-time and short-time patients in three settings: the respirator center; the unit for tubercular preschool children; and the pediatric ward.

The work with the tuberculosis unit has many facets. After 2 to 3 weeks in an isolation unit the children come to this center. They stay as long as their chemotherapy needs careful observation.

The 15 children spend their mornings and afternoons in the nursery schoolroom and in their play yard. They wear individual clothes, and the majority of the staff are in street clothes, too. Though parents are permitted to visit throughout the day, there is little visiting as one or both parents of most of the children are also hospitalized with tuberculosis. Occasionally picnics are held on Sundays for children, staff, and parents, and older siblings.

The children eat in a homelike atmosphere; they help to set the tables and serve themselves; and they prepare simple dishes with their teacher to add to the hospital fare. They also keep some pets, assisted by the volunteer services of a junior museum.

Two students from Antioch College work as ward aides with some older, maternal women.

We are at present trying to discover whether some of the trauma of separation and long hospitalization can be undone, *in statu nascendi* as it were, through educational measures and living arrangements for the children, such as having two children of the same family share a two-bed room. Educational planning allows the children to channel their anxieties and feelings of loss into active play and into relationships with workers who have roles especially assigned for each child, depending on his relationship to his real mother.

We follow the child's readjustment upon his return home through a research project of a medical student.

Emma N. Plank
Director, Child Life and Education, Cleveland City Hospital

BOOK NOTES

THERAPEUTIC EDUCATION; its theoretical bases and practice. George Devereux. Introduction by John Guy Fowlkes. Exploration Series in Education. Harper & Bros., New York. 1955. 435 pp. $5.

Planned to help persons who are preparing to work with defective or disturbed children and adults, this book defines therapeutic education as an interdisciplinary science which aims to accomplish therapeutic aims by educational means. The author states his purpose as interpreting the work of the educator to the psychotherapist and vice versa, with special reference to the organization of which both are a part, so that true teamwork may be achieved.

HUSBANDS AND PREGNANCY; the handbook for expectant fathers. William H. Genné. Association Press, New York. 1956. 127 pp. $2.

Written by a teacher-counselor in a community agency for maternal health, this book offers advice to expectant and new fathers. It is intended, the author says, for men to whom community classes for expectant fathers or couples are not available, and it is offered also as a resource for teachers of such classes.

THE EMOTIONALLY DISTURBED CHILD; papers on diagnosis, treatment, and care. Margaret Wilson Gerard. Child Welfare League of America, 345 East 46th Street, New York 17, N. Y. 1956. 168 pp. $2.25.

Ten articles by the late Dr. Gerard that appeared earlier in various publications are presented in this collection. They point out some general principles underlying the cause and treatment of some childhood problems and describe in detail the psychoanalytic techniques that the author used in dealing with such problems. One of the papers reviews the literature on tics in childhood, presents case histories of children with tics, and discusses common factors in development of these symptoms. Another, written with a co-author, is devoted to techniques for making placement in a foster or adoptive home less difficult for the child. In a paper on the diagnosis and treatment needs of the disturbed child, social workers are urged to keep alert to improvements in child-welfare practices and to the need for weighing and judging methods of care for different children.

YOUTH; the years from ten to sixteen. Arnold Gesell, Frances L. Ilg, and Louise Bates Ames. Harper & Bros., New York. 1956. 542 pp. $5.95.

This book completes a trilogy that includes "Infant and Child in the Culture of Today" and "The Child From Five to Ten." It studies the increasing maturity of children 10 to 16 in relation to physical growth, personal hygiene, emotional expression, fears and dreams, self and sex, interpersonal relations, play and pastimes, school life, ethical sense, and philosophic outlook. The study includes 165 children from a single cultural group, most of whom the authors had already studied earlier.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

FOUR DECADES OF ACTION FOR CHILDREN; a short history of the Children's Bureau. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. Dorothy E. Bradbury. CB Publication 358. 1956. 90 pp. 35 cents.

This small book tells the story of the Children's Bureau from its beginnings to the present, and includes a chapter, written by the present chief of the Bureau, looking to the future. Appendixes present excerpts from the act of Congress establishing the Bureau (1912), the Maternity and Infancy (Sheppard-Towner) Act (1921), the Social Security Act and amendments (1935, 1950), and other legislation; also a table showing grants to States for maternal and child health, crippled children's services, and child-welfare services.

SOME FACTS ABOUT PUBLIC STATE TRAINING SCHOOLS FOR JUVENILE DELINQUENTS. Children's Bureau Statistical Series No. 33. 1956. 39 pp. 25 cents.

On the basis of 109 replies to a questionnaire sent by the Children's Bureau to the 129 State training schools for juvenile delinquents in the United States, the Bureau reports an estimated number of 45,000 children as cared for in such schools during the year ended September 30, 1953. The median age of the children was 16; nearly three-fourths were boys; more than two-thirds were white. The annual cost of caring for a child ranged from $439 to $4,399—the average was $1,985. The report also gives information on admission policies, capacity and occupancy of the schools, program and facilities, personnel, and expenditures.

NEW PERSPECTIVES FOR RESEARCH ON JUVENILE DELINQUENCY; a report of a conference on the relevance and interrelations of certain concepts from sociology and psychiatry for delinquency, held May 6 and 7, 1955. Edited by Helen Witmer and Ruth Kotinsky. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1956. 92 pp. 30 cents. C. B. Pub. No. 356.

The conference reported in this publication was called by the Children's Bureau as a step toward bringing delinquency research into closer relation to basic theory in the behavioral sciences. The report includes papers presented at the conference by Erik Erikson and Robert K. Merton, whose viewpoints, the editors note, seem to converge in explanation of delinquency, although developed separately and out of entirely different bodies of theory.

YOUR CHILD FROM ONE TO SIX. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. No. 30. Revised 1956. 110 pp. 20 cents.

This latest edition of one of the Bureau's series of bulletins for parents was prepared with the cooperation of child psychologists and psychiatrists, pediatricians, preschool and parent educators, nurses, and specialists in child development. It reflects new understanding of how children grow and develop from infancy to school age, with emphasis on happy mental and emotional development.

RESEARCH RELATING TO CHILDREN. Department of Health, Education, and Welfare, Social Security Administation, Children's Bureau. Clearinghouse Bulletin No. 3. 1956. 124 pp. 60 cents.

Current research projects concerning children—their physical and motor development, intelligence, behavior and personality—and concerning education, and health and social services for them, are inventoried by the Bureau's Clearinghouse for Research in Child Life in this bulletin. Nearly 300 projects are included.

Use of funds for printing this publication has been approved by the Director of the Bureau of the Budget, September 10, 1956.

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